Hospital Library

Who Is Responsible for the Control of Surgery?

There Are Ogres in the Hospital Basement

Men at Work on Better Hospitals for Everyone

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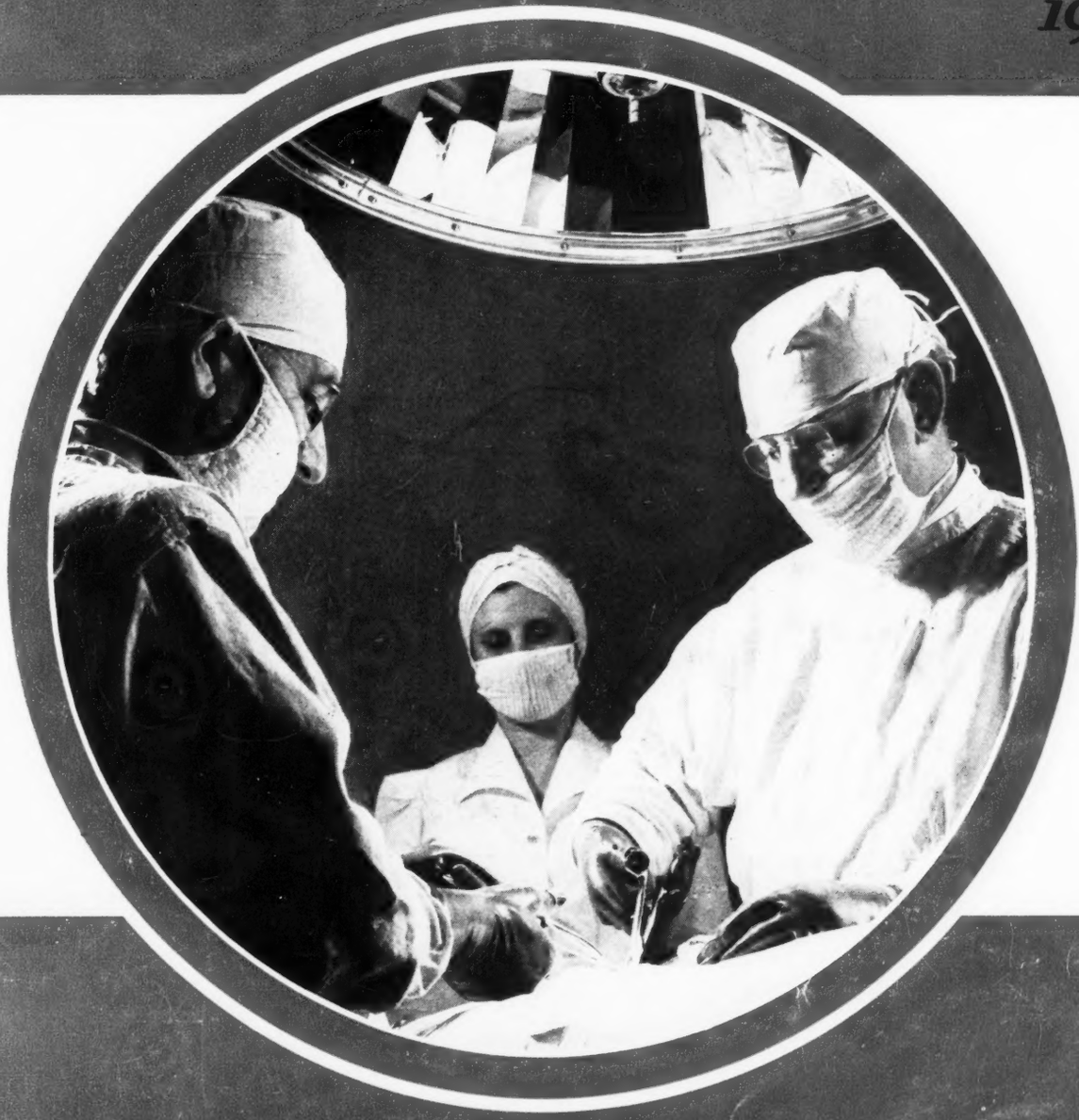

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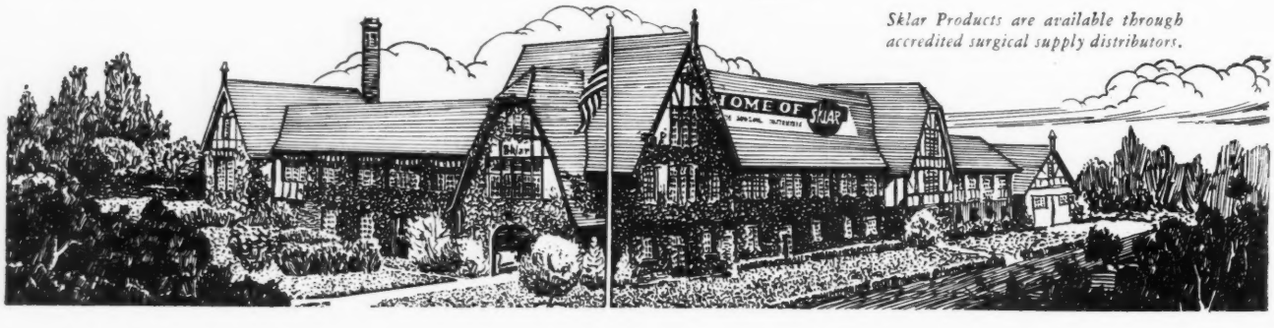

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This Month

WE INTRODUCE....

"Hospitals are in my blood," says **Robert F. Brown, M.D.,** medical director and assistant administrator of St. Luke's Hospital, Chicago, whose forthright article on administrative responsibility in the control of surgery appears on page 43 of this issue. Dr. Brown received his undergraduate and medical education at the University of Oregon at Portland. Although he intended to practice medicine, his administrative talent began to emerge in his medical school days, when he served as an executive of his medical fraternity and helped to finance his education with a couple of business sidelines.

After an internship at the University Hospital in Portland, Dr. Brown went to the Sonoma County Hospitals in Santa Rosa, Calif., for a rotating residency. Here his interest turned definitely toward hospital administration. In 1940, he attended the Western institute of the American College of Hospital Administrators, then became chief resident of the Sonoma institutions. The following year, he went to Stanford University Hospitals for a residency in hospital administration, later serving there for three years as assistant superintendent.

In March 1945, Dr. Brown came to St. Luke's in Chicago, where he has been active in the Chicago Hospital Council and other hospital and community affairs.

Frank C. Sutton, M.D., is medical director of Rochester General Hospital at Rochester, N. Y., where the program described in his article on page 61 is in effect and has met with excellent success. Dr. Sutton is a graduate of Northwestern University Medical School in Chicago, where he was a member of the class of 1938. Before going to Rochester, he was in practice in Cleveland.

Henry N. Pratt, M.D., is administrator of Memorial Hospital for the Treatment of Cancer and Allied Diseases in New York, a position he came to a year ago following his discharge from the army medical corps. Before entering the army, Dr. Pratt was a pediatrician in Boston, an instructor in pediatrics at Harvard Medical School and member of the staff of Children's Hospital. The army introduced him to hospitals; during the period of his service he was commanding officer of army hospitals in the United States, Ireland, England, Belgium and France. In December 1944, during the Battle of the Bulge, Dr. Pratt's hospital in Paris admitted more than a thousand patients and evacuated 500 in one period of eighteen hours. Apparently concluding that it must be easy to run a hospital outside a war, he returned to this country and entered the field of hospital administration.

Dr. Pratt is a graduate of Harvard Medical School and a diplomate of the American Board of Pediatrics.

The enthusiasm which **Mrs. Ruth M. Noble** brings to her work as organizer and director of patients' gardening activities at Triboro Hospital, New York, arises naturally from her own long-standing interest in gardens and flower arrangement. As an active member and former chairman of her garden club in Forest Hills, N. Y., Mrs. Noble brings home prizes with monotonous regularity; she also holds a certificate award from the state federation of garden clubs. Her garden at St. Luke's Church in Forest Hills has been acclaimed widely by connoisseurs and pictured in garden books, but her own favorite among many gardening triumphs is an apple tree which she bought for 10 cents 17 years ago and planted in her yard. Last year it yielded five bushels of delicious apples. Mrs. Noble gets lasting satisfaction from her work at Triboro, which is described in the article on page 79 of this issue. "I love people and flowers," she says, "and am delighted when I can bring them together."

James W. MacQueen, M.D., administrator of the Jefferson-Hillman Hospital, Birmingham, Ala., is a man of many interests, including astronomy, photography, bookbinding, chess, literature and raising fruit trees. As an example of how Dr. MacQueen approaches his hobbies, it should be noted that when he needed a telescope to study astronomy he got a battleship porthole and ground himself a 9 inch reflecting lens. During the depression he became interested in writing; he studied fiction writing for a while, then sat down and turned out several successful detective novels, using the pen name James G. Edwards. The novels were all about hospitals. His favorite and most lasting hobby, however, is his vineyard and orchard, which are now so productive that his two young sons are planning to go into the fruit business in self defense.

A native of Birmingham, Dr. MacQueen came North to take his medical education at Rush Medical College in Chicago. The hospital of which he is now administrator is a part of the University of Alabama medical school. At present, Dr. MacQueen is a patient there.

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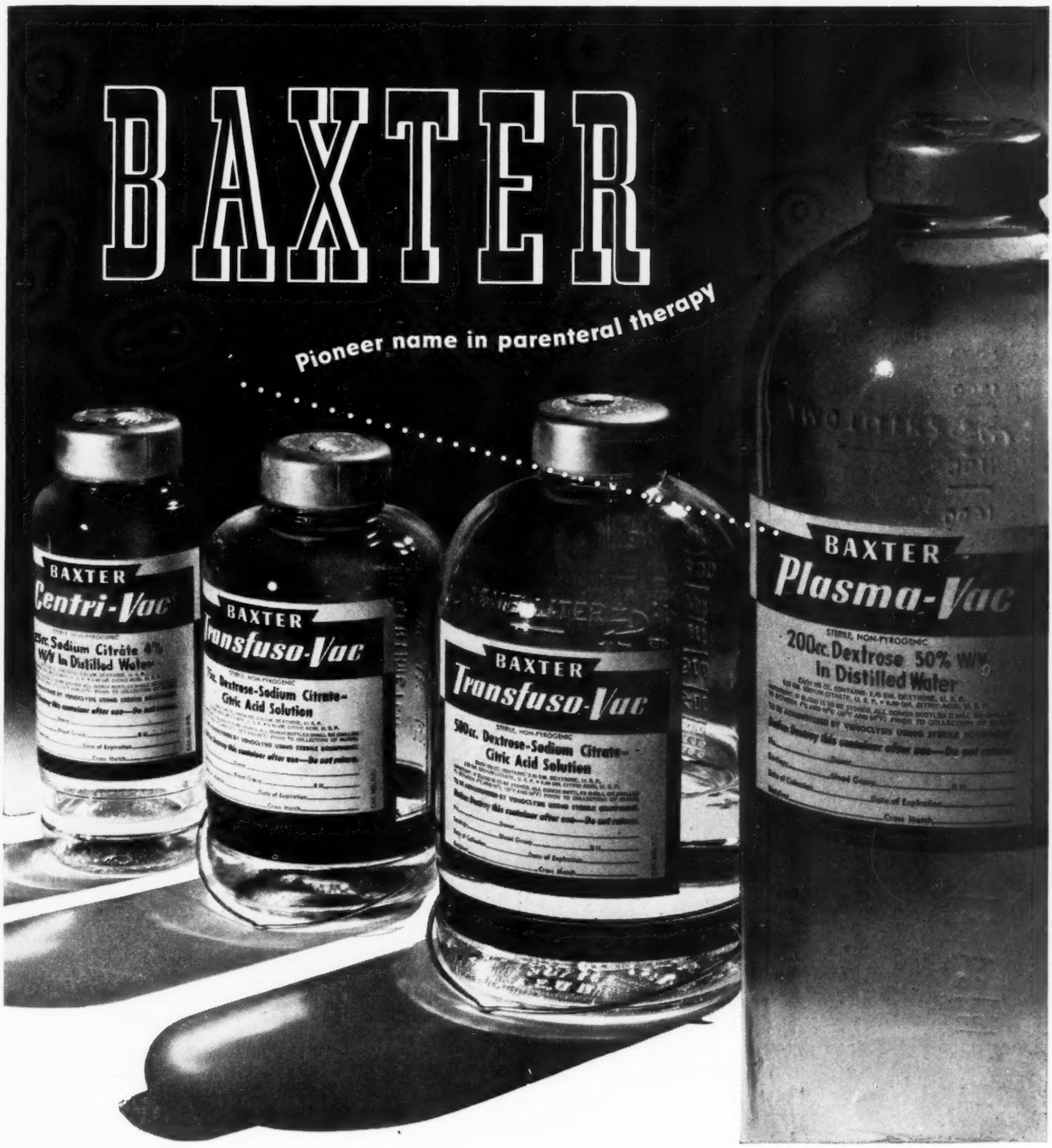

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THE ROVING REPORTER

For Our Future Citizens

In these days when volunteer aid is still essential but the wartime patriotic appeal is missing, the wise administrator is scratching his head over ways of attracting assistance of this type.

Giving full credit to both the intramural aides and the extramural helpers who labor in women's auxiliary projects is one surefire technic. Childrens Hospital, Los Angeles, has hit upon one good scheme.

In a handsome 16 page booklet reporting the services rendered to the people of Southern California by the Childrens Hospital Society of Los Angeles, much more than half of the text is devoted to volunteer effort.

After a dramatic account of the rehabilitation of just one "citizen of the twenty-first century" and snappy narrative accounts of work of the administrative, medical and nursing staffs, the educational program and the outpatient department, interspersed with appealing pictures, the booklet goes all out for the volunteers.

A spread in the middle of the book shows a photo montage of children on an aerial view of Los Angeles and its environs. The photo montage is printed in blue over which bold black lines radiate from the Childrens Hospital site to every nearby town that furnishes volunteers to the hospital.

Every right hand page in the booklet is an arrangement of photographs. Most of the left hand pages are given over to the account of the work of individual auxiliaries, only two single paragraph accounts to each page. These one paragraph summaries, signed by the auxiliary president, are displayed with plenty of white space and in two colors. It is just about impossible for even the casual reader to ignore these accounts, especially since some of them tie in with the appealing photographs of happy child patients on the opposite page.

Congratulations to Mrs. Majl Ewing, president of the Childrens Hospital Society and to Henry N. Wallace, the administrator, for his dramatic account of the contributions to the Los Angeles area of an alert staff and of a host of hard working women who are donating their energies for the aid of so many citizens of the twenty-first century.

New Twist to Music Therapy

Music therapy took a new turn recently when an arthritis patient gave a public demonstration of piano playing. Two years ago Rose Accetta of Brooklyn, a blind girl, could not move her fingers so swollen were her wrists and gnarled her knuckles. But her tone production was good as she played Tschaikovsky's "Dream Waltz" and other numbers before an audience.

Her hands so much improved, Miss Accetta asked her music teacher if she could do anything for her shoulders. Edith Otis, the music supervisor at Brooklyn Music School Settlement, with Dr. John Weinmann, director of physical medicine at Prospect Heights Hospital, Brooklyn, produced a 'cello bow to which she had wired a square block of light balsam wood so planed that the pupil's hand and wrist rested on it. Two sets of tape were tied to secure it and Miss Accetta then was able

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to hold the bow and move it across the 'cello.

The music supervisor and Dr. Weinmann have devised a wooden block which, screwed to the piano, gives support so that a person with no control over the finger muscles may play staccato and thus exercise powerless or stiff muscles. This experiment is now being used with a spastic patient.

Organ or melodeon pedaling can help the patient regain use of injured ankles; the trombone will exercise the forearm muscles; the mandolin, those of the wrist; the xylophone, wrist and forearm, Miss Otis believes.

Success Story, Diaper Division

Huntington Memorial Hospital, Pasadena, Calif., and many patients in its maternity department were smack up against a diaper shortage. Even Elgin's, a children's specialty firm in the town, could not provide the needed absorptive squares.

The hospital's women's auxiliary decided to go to the public for diapers on the theory that there were thousands of families in the area whose children had gone into training pants or panties or even bare bottoms.

The auxiliary was prepared not to be choosey about the diapers' age and previous condition of servitude. The members were willing to repair, launder and sterilize the diapers and then sell them at a nominal price to mothers and expectant mothers who were in dire need of the essential items. The funds so derived would then go into the auxiliary's own charitable work at the hospital.

Clever, indeed, was the way the auxiliary went about soliciting diapers. Remember Elgin's, the juvenile specialty firm that could get no diapers for the hospital's maternity patients. Well, Elgin's was persuaded to run a display advertisement in the local papers, soliciting gifts of used diapers for Huntington Hospital.

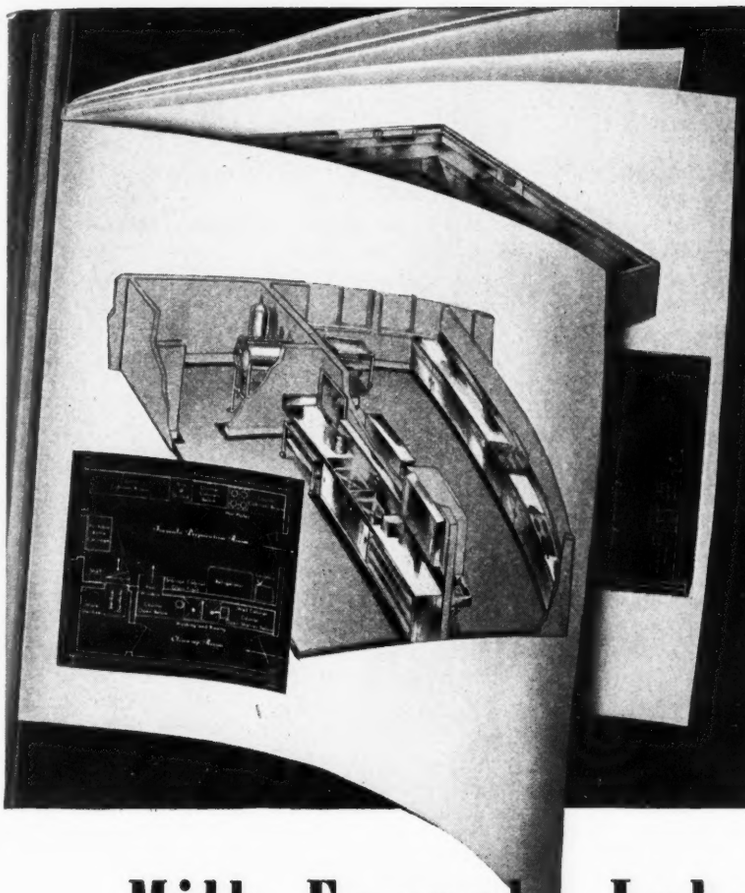
A three column ad appeared in short order; above a picture of a pert undiapered baby was the headline: "I NEED DIAPERS! Have you any for me?" And below: "We've looked everywhere but couldn't even find any at Elgin's." Elgin's two stores were then used as depots for depositing the diapers, as was the hospital itself.

The way things turned out, Elgin's lured old and new customers into their two shops on a charitable mission, stacks of hidden diapers came out for a baptism and the women's auxiliary rendered many mothers and the hospital a genuine service.

If, at the same time, the idea swelled the auxiliary's coffers by $30 or $40, who were these well dressed beggar women to turn away an honest dollar!

Baumanometers on Wheels

Repair bills declined to almost zero when the baumanometers were mounted on simple wheeled tables made by James A. Malloy, engineer at Englewood Hospital, Englewood, N. J. The box holds the cuffs and stethoscopes.



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READER OPINION

Licensing Practical Nurses

Sirs:

I am a little bit uncertain in my own thinking concerning the advisability of licensing practical nurses at this time. I have little concern for the argument that no schools exist; that more or less resolves itself into the old discussion as to which comes first, the chicken or the egg. If such an act were passed, I am sure that the schools would be started in good time, just as I am sure they will not be started until some recognition has been given to the product they are going to turn out.

It does seem desirable to set standards and maintain some degree of control over any group that must bear the responsibility of caring for the sick. Frankly, I think that irrespective of our present reaction or feeling, it is only a matter of time until some type of licensure will be adopted.

If I were to have to take a stand today I believe I would be in favor of licensing practical nurses. It would materially restrict the operation of commercial schools and might result in some degree of control over the charges which such groups might make. Today, it is common knowledge that many practical nurses working in homes are earning as much as and sometimes more than the registered graduate nurse in institutions.

With regard to the possibility of the program's attracting girls who might otherwise attend the three year nursing course, I am inclined to believe you can minimize that and it would be no more true in this instance than has been the experience in any of the other professions.

It seems to me that licensing might at least be an approach to a partial solution of the acute nurse shortage with which we are confronted.

E. E. Salisbury
Executive Director
Chicago Hospital Council

Happy to Be of Service

Sirs:

Sincere congratulations on the wonderful job you have done in summarizing the results of your questionnaire "What About Windows and Doors?" This is a real contribution to the hospital field, and I am sure that those of us who are equipment and maintenance cost conscious are grateful for your intelligent helpfulness.

L. G. Schmelzer
Superintendent
George Washington University Hospital
Washington, D. C.

First With 40 Hour Week

Sirs:

In the February issue on page 138 an article appears relative to the adoption of a 40 hour week by five Los Angeles hospitals. The Cedars of Lebanon Hospital was one of the first to declare itself for this schedule and your article apparently omitted the name of this hospital by mistake.

E. Weisberger
Superintendent
Cedars of Lebanon Hospital
Los Angeles

More Wanted, More Coming

Sirs:

I have just concluded reading an article, "Public Relations Is Part of the Job of the Medical Social Service Worker," by Dr. A. P. Merrill, in your January 1947 issue.

This article is extremely timely for me and contains such useful information that I have called it to the attention of all the chief social workers in this area. It is an aspect of their work which we have not sufficiently emphasized.

I trust that there will be further discussion of other aspects of the work of the medical social service workers' program in future issues of your magazine.

Ernest F. Witte
Chief, Social Service Section
Veterans Administration
San Francisco

More coming—soon.—ED.

Plea for Books and Periodicals

Sirs:

The desperate and continued need for American publications to serve as tools of physical and intellectual reconstruction abroad has been made vividly apparent by appeals from scholars in many lands. The American Book Center for War Devastated Libraries has been urged to continue meeting this need at least through 1947. The Book Center is therefore making a renewed appeal for American books and periodicals—for technical and scholarly books and periodicals in all fields and particularly for publications of the last ten years. We shall especially welcome complete or incomplete files of The MODERN HOSPITAL.

Contributions should be sent to the American Book Center, c/o Library of Congress, Washington 25, D. C., freight prepaid.

Laurence J. Kipp
Executive Director
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SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Sputum Technic

Question: In the plans for a 100 bed tuberculosis hospital, as published in your November issue, why are the sputum technic room and incinerator on the third floor when there are patients on all three floors? Why isn't there such a technic room on each floor containing patients' nursing units? How would the sputum cups be transported from the first and second floors to the third, and isn't this a waste of personnel time because of the unnecessary travel entailed?—E.J., Ill.

ANSWER: Ordinarily we recommend the inclusion of one sputum technic room on each nursing floor of a tuberculosis hospital, connected by chute to an incinerator below. However, inasmuch as these sputum technic rooms are to be used only to isolate the operation of disposing of sputum we feel that there is a certain bed capacity per floor below which it becomes economically impractical to provide individual floor sputum technic rooms.

In our typical 100 bed plans we came to the conclusion that for only 33 beds per floor, the devotion of space and the financial outlay involved in providing a sputum technic room on each floor would not be justified by either the saving in personnel travel or the lessening of danger from infection that would be accomplished thereby. However, we stress the point that this is a matter that should be determined in accordance with the particular operational procedures and financial status of the individual hospital being planned.—MARSHALL SHAFFER.

Fixing Ward Charges

Question: (1) What is the fairest base on which to establish rates charged to patients in hospital wards? (2) In negligence cases, when an injured person has obtained a settlement, should the charge be based on a percentage of the settlement? (3) What is the common practice in setting up consulting charges for ward patients?—A.H., Ont.

ANSWER: 1. The fundamental basis of rates is, of course, cost. Assuming that the average cost per patient per day, including depreciation on equipment and fixtures, is $8, the cost of patient care in wards will average about 10 per cent less than the average cost per patient per day in the entire hospital. This, then, would make the cost per patient per day in the wards in this case $7.20.

The lowest published rate should be for ward patients who pay the hospital but do not pay the doctor. These patients might well be charged so that the regular day rate plus the average billing per day for extras would come to 10 or 20 per cent less than the average cost per day in wards. In the example assumed, the day rate might be $3.50 and the average billings per patient per day for extras might then be from $2.50 to $3 a day.

The next higher economic group in the average hospital would include ward patients who pay not only their hospital bills but also the doctors' bills. Such patients should pay a room rate per day plus an average cost per day for extra services, the combined sum of which would equal the actual cost per patient per day in wards.

2. It is not clear to me whether the rate that the doctor should charge or the rate the hospital should charge is sought. If it is the latter, the hospital should certainly charge its regular ward rates, plus extras, so that the total billing per patient per day would at least equal the hospital's total cost.

3. There should be no consultation charges to service patients. Some hospitals have entirely eliminated consultation fees for any type of patients. This has been done in the interest of better medical care in hospitals. However, it is still a common practice for the consultant to charge a fee to the patients of other doctors. Certainly, these fees should be much lower for ward cases than they are for private room cases.—E. W. JONES.

Partitions for Privacy

Question: What types of room accommodations are being provided in most of the hospitals that are being built or planned today? —K.R., Ind.

ANSWER: There are many different opinions. Many persons believe that a well designed and equipped four bed room with either permanent semipartition cubicles or permanently installed curtain cubicles to give each bed some privacy when necessary is better than is a two bed room.

Another type of so-called semiprivate or private accommodation is the usual big ward designed for from 20 to 30 beds with each bed provided with its own cubicle in the form of a semipartition or three fourths height partition on each side. This type of private patient accommodation for a hospital serving the middle and lower income groups would be well worth investigating. Some excellent installations of this kind have been made and they have worked out very satisfactorily. (Samaritan Hospital at Troy, N. Y., has some of these units.)

On a nursing unit made up of any combination of multiple bed rooms, provision must be made for two or three single rooms for each 20 beds in the multiple bed accommodation. These rooms, of course, should take care of the seriously ill, postoperative and other patients who would be disturbing to the group or whose own condition makes privacy an essential condition of their recovery.

It also would seem that from 20 to 25 per cent of the total beds to be added might well be in small, low cost private rooms.—E. W. JONES.

Charity, Courtesy and Loss

Question: What is the difference between charity, courtesy and loss, in reference to the hospital office?—Sr. M.L., Ill.

ANSWER: Charity is that increment of hospital service given voluntarily to needy indigent patients without thought or attempt at recovery.

Courtesy is commonly thought of as a discount to certain groups, such as members of the staff and other hospital personnel.

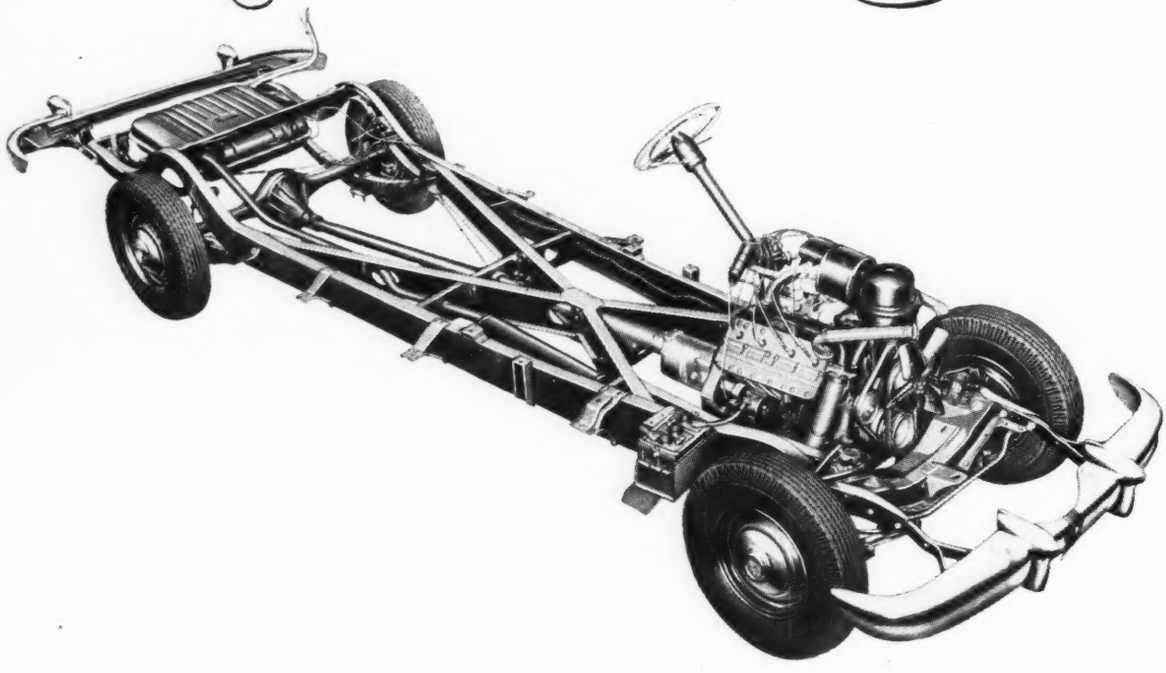
Loss has to do with lack of collection of patients' accounts which had previously been thought to be good.—ROGER W. DEBUSK, M.D.

For Better Staff Work

Question: What can hospitals do to assure better and more responsible medical staff organization in the future that will effectively control the professional activities?—M.H., Ill.

ANSWER: The procedures outlined in the American College of Surgeons bulletin on "Minimum Standards for Hospitals" cover this subject very thoroughly, as does Dr. Malcolm T. MacEachern's book "Hospital Organization and Management" (the second edition is now available). If a hospital administrator and his board of trustees will insist that the medical staff organization be conducted in accordance with the principles set forth in these two publications, they should have little trouble.—E. W. JONES.

Cadillac



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LOOKING FORWARD

Disaster Drills

IN AN article in this issue describing how the staff and facilities of his hospital were organized to care for victims of the train disaster near Altoona, Pa., last month, Robert L. Gill makes a brilliant suggestion: Why not make National Hospital Day the occasion for community disaster drills?

In the recent emergency, Mr. Gill reports, the injured were cared for more quickly because "so many people remembered instructions and rehearsals from 'blackout' days." Catastrophe drills should be staged at least once a year, Mr. Gill believes, with every community agency taking part. "It takes a catastrophe to make one fully realize that preparation for disaster has an important place in hospital work," he says.

Plainly, community disaster drills are not likely to materialize unless the hospital takes the initiative in organizing them. Plainly, too, the hospital has a lot to gain from this activity, not only in better functioning when emergencies arise, but also generally by taking its rightful place as the focal point of all community health agencies and programs.

The suggestion that such drills be held on National Hospital Day is a sensible one. Too often, Hospital Day observances have been without specific point and purpose. Like the small boy who calls, "Look, Ma! No hands!" many hospitals have used the occasion simply for calling attention to good work. If it can also serve to improve relations between the hospital and the rest of the community in a way that will aid the hospital to do better work, National Hospital Day will take on added meaning.

Newspaper Stories

A NEWSPAPER reporter called The MODERN HOSPITAL the other day to ask about a certain hospital. We said it had a fine reputation.

"Not with me," he declared. "They just tried to brush me off on a story. First they pushed me around from one person to another—and none too gently, either. When I did get someone in authority, he wasn't going to tell me what I wanted to know."

"Maybe he couldn't," we suggested. "Maybe you were after information he wasn't in a position to give you."

"If there was a reason, why wouldn't he tell me?" the reporter asked. "Besides," he went on, "that couldn't have been the case, because he finally gave me what I wanted—after I got nasty, too.

"The trouble is," he concluded, "I'm mad at them now for the way they treated me, and I won't go out of my way to make the hospital look good when I write the story."

We made a stab at explaining how overworked and harassed most hospital people are today, but he wasn't having any of that.

"Nobody's too busy to be civil," he said.

Then he told us about another hospital story he'd worked on, a few weeks ago. This one had been a real tragedy, an infant death caused by a wrong injection.

"The superintendent of the hospital was swell," the reporter recalled. "He gave me all the facts right away, and a complete description of how it happened.

"Then he explained how a damaging story in the paper might ruin the person responsible for the accident, who was all broken up about it anyway. And he pointed out how a story like this might needlessly frighten people who had babies, or were going to have babies, in hospitals everywhere.

"We got the full story that time," the reporter said. "But we didn't print it."

Charity Rates

I DO NOT believe that government hospital or medical (care) is desirable or necessary, but I do feel, if this is to be avoided, each hospital group and each medical staff and each community must do all it reasonably can to lighten the cost load of those ill who are of limited income yet who must, under present conditions, pay the cost not only of their own illness but of others who cannot pay."

With these words in his annual report, N. R. Graham, chairman of the board of trustees of Hillcrest Memorial Hospital at Tulsa, Okla., puts his finger squarely on a sore spot in today's hospital economics. In far too many cases, hospital charges for paying patients have to be higher than they ought to be, because payments from agencies assuming responsibility for nonpaying patients are lower than they ought to be. Frequently, city, county and state charity cases are paid for at rates far below the actual cost of their care. Unless the hospital is richly endowed and income is available for such cases, the difference must be made up in earnings from those who pay their own way.

Inevitably, this added burden is what makes hospitalization expense a hardship for many families. Unquestionably, too, it adds a complicating factor to the hospital-

Blue Cross relationship, since Blue Cross payments must also absorb a fraction of the charity cost.

The chances are that this problem will not be wholly solved. Every hospital has to care for some patients for whom no payment at all can be collected; in the absence of adequate endowment, there is no way to avoid spreading this cost among the paying patients. But where some agency of government is responsible, every effort must be made to collect a rate commensurate with actual costs. In many recent instances, hospitals have obtained substantial rate increases from such government units by pointing out, with adequate supporting data, that existing rates were insufficient and resulted, in effect, in a discriminating tax on paying patients.

Publicity often helps when hospitals are seeking such a rate adjustment. When the full facts are known, most people want to see the hospital fairly treated, and the public officials or bodies which control rates are usually responsive to public opinion.

Whatever methods are used, it is the clear duty of hospital administrators and trustees to work ceaselessly toward a fair rate for indigent care. To give it up as a bad job and add another dollar to private room rates, as has often been done, is to shirk the hospital's responsibility to the whole community.

Read Any Good Books Lately?

A FREQUENTLY noted complication of modern life is the necessity for doing such a prodigious amount of reading. Apart from the huge volume of occupational reading now demanded of people in all technical or professional fields, there are also newspapers, magazines and books without number on the required list for everyone with any curiosity about what is going on in the world.

Obviously, the task is beyond our time and capacity for accomplishment; our only hope of keeping even reasonably abreast of the times lies in our ability to make a wise selection from the mass that is thrust upon us. In reading as in everything else, to choose intelligently we must have purpose and plan.

Stated broadly, the one common aim of all serious reading is to add to our understanding of the world we live in and the people who inhabit it. This kind of reading, certainly, should be worth while for the hospital administrator, whose effectiveness is measured largely in terms of success in handling human relationships.

How well is this purpose served by the reading most people do? Professional reading, obviously, has its place; there is no other way for the reader to add as much needed knowledge of the technical world of which he is a part. Beyond this point, however, reading often breaks down into patternless shadowboxing with a random sample of newspapers, magazines and books.

Here precious time can be saved. The person who really values time can usually cut newspaper and magazine reading to a minimum of fast scanning for essentials, ignoring the vast quantity of trivial and bizarre detail which may divert but scarcely will reward. When the reader learns, with the aid of a little self discipline, that he can get along nicely without keeping posted on the daily antics of his favorite senator, movie actress or comic character, a lot of periodical reading can be skipped entirely. Anything of lasting value that may thus be missed for the moment will soon come to light. Wisely used, time will aid instead of hindering choice.

Time is a powerful ally, too, in the selection of books. Nobody needs to read a book the very day or week or month it appears. If it is worth reading at all it will be on library shelves a year or 10 years hence. As a matter of fact, the books which offer the richest harvest in human understanding have been in libraries for hundreds of years. There may be contemporary historians or biographers who can tell us as much about how human beings behave as Thucydides, Herodotus and Plutarch, but we cannot yet know who they are. The wisdom of Plato has not been diminished by 2500 years of developing science; administrators with any responsibility for teaching others probably have more to learn from "The Meno" than from a carload of modern pedagogical textbooks. Whoever seeks to know the meaning of communism will do well to shun its apologists and critics alike until he has read Marx.

"But there is not time for all this!" cry those who will even consider it, and they are few. There is not time—except for those who make time. Possibly the best way to begin is to take half an hour, which everybody can surely spare, and read Ecclesiastes, which says among other things: "Better is a handful, with quietness, than two handfuls with labor and striving after wind."

State Surveys

FROM the American Hospital Association comes a report indicating that as state surveys of hospital facilities are completed, less than 3 per cent of hospitals from which information is requested fail to furnish it. This is a splendid record—possibly one that no other field or profession could achieve.

It is still a fact, however, that some 3 per cent have failed to cooperate, and that others have submitted incomplete or late information schedules. The hospitals that are falling down on this job are hurting everybody. The success of the whole hospital construction program depends upon the completeness and accuracy of the surveys, and the speed with which needed additional hospital facilities can be furnished under the law depends on the speed with which the surveys are finished.

It takes time and money to do the job, but the fact that 97 per cent of hospitals are getting it done demonstrates that this is not a prohibitive hurdle. In most cases the cause of delay is negligence or failure to realize the importance of the project. Don't let your hospital be one of the laggards!

Administrative Responsibility for the Control of Surgery

ROBERT F. BROWN, M.D.
Medical Director and Assistant Administrator
St. Luke's Hospital, Chicago

WITH COMMENTS BY:

A Nurse Administrator—A Lay Administrator—

A Medical Administrator—Two Physicians—A Trustee

THE hospital should render good care to the sick and injured of the community and in doing so it must give every moral and legal protection to each patient. The board of trustees of every hospital is charged with this responsibility.

If unnecessary or harmful surgery is being performed by members of the hospital's medical staff then the board of trustees is not discharging its duty. The board of trustees must exercise this responsibility in two ways. First, it must extend surgical privileges to qualified doctors only and, second, it must judge the performance of these physicians.

It is immediately apparent that in the great majority of hospitals the appointment of physicians is the responsibility of a lay board which does not have the qualifications *per se* to select competent physicians. Furthermore, the analysis of the quality of surgery performed can be properly judged only by trained physicians.

Let us develop the technic by which a hospital board can exercise the "reasonable care" legally demanded of it in the selection of a medical staff and by which it can appoint to its staff physicians who are fully competent to practice surgery. The lay board must depend upon the judgment of those who are able to advise as to the competency of the physician, both in selecting him for staff appointment and in judging his surgical ability. Obviously, then, the medical staff itself is the only jury in the hospital which has the ability so to advise. In order to advise, the medical staff must be an organized body. This is the essence of Clause 1 of the minimum standard for approval of hospitals by the American College of Surgeons.

The organized medical staff should examine applicants in accordance with the rules of the hospital and make recommendation to the hospital board concerning the appointment of the applicant. The board should not appoint physicians to the staff without the approval of the medical staff. Appointments should be made annually and each physician should be notified of his appointment in writing.

Qualifications for membership on the staff should be determined by the medical staff organization and should follow those advised by Clause 2 of the A.C.S. minimum standard. In addition, the medical staff should establish qualifications for those physicians who shall be allowed to practice major surgery. This, then, completes the advisory process which the organized medical staff renders to the hospital board in the appointment of medical staff members.

Dr. Frank S. Gibson presented a paper entitled "Minimum Qualifications to Practice Major Surgery" at the twenty-fifth annual hospital standardization conference in Cleveland in which he pointed out the minimum qualifications necessary to practice surgery as set up by the member hospitals of the Cleveland Hospital Council. These represent the concerted action of a community toward raising the standards of surgery above the minimum level.

Minimum Qualifications to Practice Majory Surgery

"1. Membership in a recognized local organization of doctors of medicine whose membership includes practitioners of both general medi-

cine and the specialties and which has state and national associations.

"2. Either (a): Two full years of hospital training, at least one of which shall have been in general surgery in a hospital approved for training surgical residents by the American Medical Association. In case of surgical specialties, the training shall have been in a hospital approved for such special resident training by the American Medical Association.

"Or (b): Membership on the active visiting surgical staff of a Cleveland Hospital Council member hospital and classification to do major surgery."

Rules of this type should be set up by the medical staff of every hospital. In hospitals whose medical staffs are highly specialized the standards may be still higher than those listed. Certainly, no hospital should have standards lower than these accepted in Cleveland.

These qualifications should be a part of the medical staff constitution or, less formally, they should be written rules of the medical staff when officially approved by the governing board. In small hospitals of from 25 to 50 beds it is not inconceivable that such rules could be made a part of the constitution of the hospital provided, of course, that they were incorporated with due and proper medical authority. Inclusion of medical staff membership qualifications and standards for the practice of major surgery in the hospital constitution may furnish the small hospital a means of better staff control.

The community of Cleveland as reported by Dr. Gibson defined the practice of major surgery as follows:

Definition of Major Surgery

"1. Operations within or upon the contents of the following cavities: (a) the cranium; (b) the thorax, and (c) the abdomen, including the pelvis.

"2. Other operations which, because of their locality, the condition of the patient, their difficulty or the length of time required to operate, constitute a distinct hazard to life.

"3. In case of doubt or dispute the surgical authority of the interested hospital shall determine whether an operation is major or minor."

A similar definition should be established by each hospital in setting up control of major surgery. This definition is concise and will lend

Comments on "Control of Surgery"

Nurse Administrator: "Vigilance Is Needed"

MUCH has been written about the various methods that might be used to assure the community that good medical care is being given to the patients in the hospitals and many model plans have been made available to hospitals interested in providing patterns for controlling medical care.

Why, then, is there still a great need for trustees to practice great vigilance even when good standards and procedures have been adopted?

Although the actual official appointment to the medical staff must be made by the board of trustees, it is the medical group that makes the deciding recommendation. In a small community hospital not connected with a medical school and concerned primarily with giving care to pay patients, the medical group is often reluctant to refuse to recommend the appointment of some doctor.

If the qualification of the applicant can be interpreted, and if necessary rather broadly, to be such as to meet minimum standards and if no one reports frank scandal, widely known to the public, the physicians will usually recommend the admission or reappointment of the man to the staff. They would want the same done for them under similar circumstances.

Since the board of trustees is a lay group and admittedly cannot judge professional credentials, it can do little else in most cases but follow this recommendation and may end up with having appointed to the staff men of greatly varying qualifications, caliber and integrity.

Once the doctor is a member of the medical staff he becomes a part of a group. This group, to lessen its individual and collective vulnerability, develops a strong loyalty and a protective banding together. When a member of the group is attacked by criticism arising from any source, out of group loyalty it will protect its member and, by stretching matters, find justification for the conduct of the member being criticized. Again, the trustees and administrator can often do little but accept whatever recommendation the medical group offers.

So because rules can be interpreted broadly according to the letter rather than the spirit of the law and because any group tends to protect its own members from persecution unless the conduct of the member is flagrantly out of order, the trustees and administrator cannot be content to sit back once good standards for appointment and performance are set up but must maintain eternal vigilance over the medical activities of the hospital. How this is best done will vary in each hospital, for no two situations are alike except in that in each case good total care must be obtained for the patient.

—EVA H. ERICKSON, Olean General Hospital, Olean, N. Y.

Lay Administrator: "Hits at the Heart of the Problem"

DR. BROWN hits right at the heart of the problem of raising standards for surgical procedures in our hospitals when he emphasizes the fact that the responsibility for high standards is in the hands of the board of trustees. I feel that he did not emphasize this fact, however, quite as strongly as he should. He states that control of standards is the responsibility of the board of trustees and the administration and also that they have the right to exercise such control. I believe they have not only the right but the obligation to control the standards not only for surgery but for all the practice of medicine in hospitals.

We should build high standards for the practice of internal medicine and

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all the other specialties. A good medical diagnosis is of first importance. I am firm in my belief that if we had better medical diagnoses prior to surgery many surgical cases would not be necessary.

Too often administrators of small hospitals feel that articles of this type were not written for their benefit because their institutions are too small to apply the principles, but these high standards seem practical and workable in the smallest hospitals. I have been the administrator of a small hospital and the need seems more apparent there than in large hospitals which have been better organized, probably, from the first.

The economic difficulties experienced by most hospitals through the depression have caused fear of empty beds to control our actions in raising our standards. We have felt that we could not afford to clamp down too tightly for fear we would lose some business. I believe that the hospitals that enforce their regulations and raise their standards high will be the ones to suffer the least when and if economic conditions settle down to a lower pitch, even should another depression hit us at some future date.

Dr. Brown does not quite make clear how the board of trustees can control a medical staff and its standards. I should like to advance the idea which is being used in many hospitals: that the board of trustees select chiefs of the service they wish to recognize in the hospital. Small hospitals may have only two services: medicine and surgery. They may, however, include obstetrics and they may go so far as to include pediatrics. The larger hospitals, of course, can go on to a more complicated staff organization and have the board of trustees appoint the chiefs of all the specialties that are being practiced in the hospital, when men on the staff are qualified as specialists.

These chiefs of services can be formed into a medical board, or some such organization, to meet periodically and review the professional work of the hospital, with the administrator as an ex officio member. An interrelations or interconference committee can be formed by the board of trustees and the medical board with two members from each body, meeting whenever the occasion may arise.

I find that boards of trustees are anxious to know more about the professional side of the hospital, but they are busy attending to the financial side and too often leave the professional management to the medical staff without giving it any authority whatever to function.

Every hospital should be a teaching hospital regardless of how small it may be. If it has no one to teach but its own staff, it should perform this function. The staff should be encouraged to attend the necropsy examinations as well as the medical staff meetings.

The same control should be placed on all of the services of the hospital that is applied in surgery. There are different ways, however, of maintaining this control in the various services. In surgery, we find that a tissue committee is invaluable. This committee consists of members of the medical board and meets to study all of the normal tissues removed, if any, and to study the patients' charts to determine whether or not justification has been set forth for such removal of normal tissue.

In the event that normal tissue is removed unnecessarily and without justification, the tissue committee makes its report to the medical board which in turn notifies the surgeon involved of the findings and gives him an opportunity to appear before the medical board to explain his action. If he cannot satisfactorily explain or justify his action, then the medical board must recommend to the board of trustees that this man be dropped from the staff, at least, until such time as he can convince the medical board that his work will be entirely satisfactory.

—LAWRENCE PAYNE, Baylor University Hospital, Dallas, Tex.

(*Continued on Page* 46.)

itself well to clear interpretation both by those surgeons working under it and by those who administer it.

Appraisal of the surgical performance of individual surgeons is also the responsibility of the hospital board and the administration. This function should be performed through the internal control of the medical staff which receives its authority from the board. The department of surgery, with the approval of the hospital administration, should designate a committee of qualified surgeons to serve as the surgical authority.

When the surgical ability of a staff surgeon must be questioned for cause, the facts should be searched out by the departmental committee which subsequently, together with the administration, should direct disciplinary measures. If the judgment of the committee recommends removal of the physician from the medical staff or cancellation of the physician's surgical privileges a written recommendation should be directed to the board of trustees.

The board of trustees has the choice of two courses of action: (1) the board may remove the physician from the staff immediately or (2) it may decide that the physician in question should not be reappointed for the subsequent year.

If the cause of action for removal of the physician from the medical staff is a dangerous lack of surgical ability or a flagrant violation of hospital rules then the hospital is morally bound to take action. The board can discharge the physician from the staff immediately or it can remove his surgical privileges and subsequently not reappoint him to the medical staff at the time annual reappointments are made.

If the cause of action is of more delicate nature, such as might surround an ethical question, then the physician should be removed from the staff by the method of not reappointing him for the year to follow. These methods adequately substantiate the necessity of formally appointing all members of the medical staff year by year.

The method of not reappointing a physician to the medical staff at the time of the regular annual reappointments is less rapid but is less liable to legal redress. This completes the technic of control of the membership of the hospital's medical staff. Any

application of the foregoing principles should be made only with the support of proper legal advice and in full compliance with the constitution and articles of incorporation that govern the hospital.

The courts have given numerous decisions sustaining both the right of a hospital to choose its staff and the right to exclude undesirable and unqualified physicians. Emanuel Hayt has elaborated upon the duties of the board of trustees in an article in the June 1945 issue of *Hospitals*. Dr. Malcolm T. MacEachern has presented an up to date chapter on the medical staff in his second edition of "Hospital Organization and Manage-

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Medical Administrator: "The Qualifications Should Be Higher"

WHILE we cannot expect rules and regulations to produce a Utopia from the standpoint of the practice of surgery, I believe that Dr. Brown has not gone far enough in his suggestions for the administrative control of surgery.

Under minimum qualifications to practice major surgery as outlined by Dr. Frank F. Gibson, a man with one year's surgical training following his internship is approved for performing major surgical operations. Such a requirement is entirely too low. Qualifications for major surgical privileges should, in my opinion, require either membership in the American College of Surgeons or that the surgeon be a diplomate of the surgical specialty boards. Certain hospitals today are demanding that a man have his surgical specialty board approval before he is raised from the junior ranking positions on the staff of the hospital with which he is affiliated. Any man who does major surgery and does not have these qualifications should be working under the sponsorship of a man who does have them.

In addition to the surgeon's having the proper qualifications, there should be an adequate check to compare his preoperative and postoperative diagnoses and to ascertain that the pathological diagnosis of the tissue removed at operation supports the preoperative diagnosis.

While it is readily understandable that such qualifications as those outlined might be difficult to demand of the staff of a small hospital in a small community, nevertheless the patient should not be denied the services of the adequately trained surgeon simply because he lives in a rural area.

Were it possible in the smaller community to place a little more emphasis on specialization in the surgical field so that all doctors did not set up as general specialists and so that the surgeon would leave everything outside of this field to the general practitioner, the patient might be safer and the medical profession happier and there might even be fewer of our great medical family passing on at an early age from coronary disease caused by overwork.
—FRASER D. MOONEY, M.D., Buffalo General Hospital, Buffalo, N. Y.

Physicians: "Exchange of Ideas Improves Esprit de Corps

THE fundamental principles of sound hospital management emphasized by Dr. Robert F. Brown in his article comprised the minimum standards that should be required of any hospital.

A feature not emphasized by Dr. Brown is the liaison between the administration and governing board of the medical staff. The monthly staff meetings required in recognized hospitals should be the means whereby the medical staff can present its problems to the administration and the hospital administrator can advise the medical men regarding problems of administration and proposed changes. This exchange of ideas will have the effect of increasing the esprit de corps of the hospital immeasurably.
—BENJAMIN ETSTEN, M.D., and JOHN McCLINTOCK, M.D., Albany Hospital, Albany, N. Y.

Trustee: "Governing Body Is Responsible"

DR. BROWN'S article is thought provoking and can be read with profit by all members of hospital boards throughout the country.

It seems to me, however, that Dr. Brown has not touched on the core of the situation, namely, the governing body of the hospital. Too often, hospital trustees are chosen for their names, their money or their standing in the community, and not for interest in and knowledge of hospital administration. Too often, trustees attend meetings irregularly, vote as indicated by the president or the administrator and forget the institution until the next meeting.

Trustees should impose the following requirements on the staff:

1. Certification by the American Board of Surgery of all doctors practicing major surgery.
2. Strict control of all surgical practice by the chief of surgery or the president of the medical staff or, preferably, by both.
3. A pathological audit at least quarterly.
4. A medical audit at least annually from the president of the staff, presenting frankly and in detail the work, the attitude and the qualifications of each member of the medical staff.
5. The inauguration of a medical administrative committee as a liaison between board and staff. This committee should be composed of two members of the board, two members of the medical staff, the president of the medical staff and the superintendent. Its duties should be all inclusive in the medical affairs of the hospital and it should report directly and in writing to the board of trustees.
6. The attendance periodically of the president of the staff at its meetings for a general discussion of all medical aspects of the hospital.

The board of trustees should be prepared to act promptly and fearlessly in the removal of a physician from the surgical privileges of the hospital and from the staff if the facts clearly indicate such a course. The obligation of the trustees is to the patient and to the committee solely. Too infrequently does the trustee realize or understand his personal liability in permitting physicians who are not properly qualified to practice in his hospital.
—FRANK F. SELFRIDGE, Highland Park, Hospital, Highland Park, Ill.

ment." Both of these sources and the "Legal Guide for American Hospitals" by Hayt and Hayt should be in the "used" library of the hospital administrator for they are outstanding references upon the subject of medical staff control.

Several national agencies have exerted profound influence upon the development of hospital standards. Each has exerted an increment of influence which has raised the general standards of hospitals. Boards of trustees may receive inestimable aid from these groups by accepting the challenge which they offer.

Institutional members of the American Hospital Association are considered to abide by the code of ethics approved and adopted by the American Hospital Association and the American College of Hospital Administrators. The responsibilities of the hospital and its board of trustees to render good hospital care to the sick and injured of the community and, in so doing, to render every reasonable protection to the patient, both moral and legal, are the essence of this code.

Approval by the American College of Surgeons certifies that the hospital has met the minimum standards for the proper care of the sick and injured, with all the resulting benefits to patients and to standards of the medical profession and the hospital. Registration and approval of hospitals for intern training by the Council on Medical Education and Hospitals of the American Medical Association and approval for training residents in surgery and the surgical specialties by the American College of Surgeons and the various specialty boards also effect improvements in the hospital's service.

A hospital that is approved for the training of interns and subsequently is approved for the training of residents accepts more responsibility to the community as each approval is obtained; and the presence of interns and residents in turn increases the quality of the care rendered.

To become registered by the American Medical Association the hospital must maintain laboratory facilities under competent supervision; a similar requisite is included in the minimum standard for approval of hospitals by the American College of Surgeons. A pathologist who is certified by the American Board of Pathology should supervise the laboratories. Such a laboratory under the supervision of a certified pathologist becomes the means of measuring the operating technic of the surgical staff.

All surgical tissues removed during operations should be studied both by gross and by microscopic methods by the pathologist. Here, the medical staff and the hospital administration find a valuable instrument in discovering unnecessary surgery and even harmful surgery. If a surgeon removes many normal appendixes from patients with a preoperative diagnosis of acute appendicitis, this information should be brought to the attention of the surgical authority of the hospital and the administrator.

How many normal ovaries are removed from normal young women for vague symptoms of menstrual pain? How many laparotomies (surgical openings of the abdomen) are done only after adequate surgical consultation? These questions can be answered only by the continual medical audit of the cases in the hospital. These very questions are the fundamental reasons why monthly medical staff meetings must be held.

In these meetings the medical staff should review: (1) the cases which have presented difficult diagnoses; (2) the cases which have had unusual complications, and (3) the pathological findings on cases which have gone to postmortem examination.

The benefits are twofold: education of the medical staff and holding up for surveillance of the staff the surgery performed in the hospital.

To be approved for intern training by the American Medical Association the hospital must perform postmortem examinations on at least 15 per cent of all patients who die in the hospital. The percentage of necropsies is a valuable barometer for the medical staff and the hospital administration. The higher the necropsy percentage, the more assured the administration can be both of the sincere interest of the medical staff in educating itself and of the quality of the medicine and surgery being practiced in the hospital.

Certainly, a hospital board has the obligation to ask that the necropsy rate be raised to at least 35 per cent. Some teaching hospitals have percentages of more than 50; and in all cases the percentage may be considered proportionate to the quality of medical care rendered in the hospital.

The hospital administrator is the executive officer of the board of trustees. The burden of enforcing the rules of the hospital and of carrying out the disciplinary action necessary to maintain the surgical standards of the hospital most often fall on his shoulders. Tact and judgment, strengthened by experience, are his powerful weapons which must provide every moral and legal protection to all patients who enter the hospital.

Administrative Capsules

- Individual ward patients are constantly being asked to make sacrifices in the interests of the group, but these sacrifices have definite limits. These limits determine the size of ward units and the number of separation rooms.

- The Travelers' Aid Society ought to be invited to establish branch offices at strategic points in the large hospitals of our country.

- No physician who is worth his salt can be satisfied with the postponement of death as the only reason for his presence at the bedside. He must help to make life endurable during the remaining period of illness, no matter how long it lasts.—E. M. Bluestone, M.D.

There Are OGRES in the Hospital Basement

E. A. VAN STEENWYK
Executive Director
Associated Hospital Service of Philadelphia

ONCE upon a time when the world was young and hospitals were uncrowded, and when a W.P.A. project could be set in motion by just writing a letter to a congressman, a horrible and wicked ogre by the name of *Hospital Occupancy* went up and down the land scaring the life out of poor unsuspecting hospital superintendents.

The ogre lived everywhere. He'd pop out from between the covers of books on statistics. His ugly face could be seen in reports to the boards of trustees. He lived in the minds of donors and doctors. Even patients whom no one ever told anything and who were not supposed to see anything or feel anything came to know about the ogre.

When you think about it now it seems strange that patients should have been unaware of his existence for so long because it was the fresh green lettuce which patients brought that the ogre most adored. Yet at the time it seemed all right. The patients were finally told, and the doctors and donors and all the little children, that unless more patients came to stay at the hospital for longer periods and brought more fresh green lettuce to the ogre he would slay the hospitals. In the quaintly direct language of the day, he'd "have them taken over" by the *Government.*

Of course, no one wanted this to happen and so all the hospital superintendents and the nurses and doctors and all the trustees and employes of hospitals went scurrying about to find a way either to satisfy the ogre or to overcome him.

Since the ogre insisted upon patients' fresh green lettuce, it was, of course, difficult to satisfy him. Patients liked to keep the lettuce themselves because in that time, just as in this, everybody had to live and the ogre took so much lettuce from the infrequent patients forced to stay in the hospital that they were scared of him, too.

While patients were scared by the ogre, they nonetheless liked hospitals more and more. The doctors were just beginning to use serum to fight pneumonia and many patients' lives were saved by visiting the hospital. In addition, experience showed that mothers and their babies had a better chance for life if birth occurred in hospitals. Also, hospitals always gave their service free to patients who were without the necessary lettuce. In fact, in Philadelphia at that time only about 60 per cent of the patients brought any lettuce at all, and half of these were called "part pay" because they brought only torn bits of lettuce instead of the nice fresh lettuce which "full pay" patients brought. The remaining 40 per cent were all free patients.

The hospital superintendents and trustees, the doctors and nurses pondered over this dilemma a good bit. If the existence of the ogre had not been so unvaryingly certain they would have just said "poof" to him and gone about giving away all their service which was what everybody wanted anyway, but it wasn't this easy. The ogre made good his threats in many areas. In one year he killed several hundred hospitals and *Government,* his pal, gradually took over more and more hospital beds. By 1936 *Government* had more than two thirds of all the hospital beds in the country. Those who watched the ogre at work knew that he'd succeed too unless something drastic was done.

Of course, this was long ago and no one quite knows how everyone began talking about the same method of satisfying the ogre at the same time, but anyhow superintendents and doctors, trustees, nurses, employes and patients all began to talk about Blue Cross, how it would slay the ogre if everybody chipped in and organized their strength behind it.

The secret of Blue Cross was that it pooled a small amount of everybody's lettuce and since this made it possible for everyone to use the hospital as he needed it, the ogre got

lots and lots of patients' fresh green lettuce from Blue Cross. This couldn't happen overnight, of course. When you think of it, it took Alice a long, long time to follow the rabbit down the well, and it was the same with Blue Cross.

Some of the doctors said that Blue Cross was just another of the ogre's pals, like *Government,* and the first thing you know, the ogre would carry out his threat through Blue Cross. Some of the patients thought that Blue Cross was a fake, that the ogre was getting so strong that nothing could stop him. Even a large number of the hospital superintendents and trustees, while giving a friendly eye to Blue Cross, winked over to the ogre, as if to say, "We know you're too big to give battle to seriously, just let us have our final fun."

Government could hardly maintain his composure; every once in a while he'd come out to give directions, but it was something like suggesting that a chop here or there would lay the tree more conveniently, and then he'd walk off fast for fear someone would catch him laughing. Getting knocked off by an ogre isn't supposed to be funny and, as a pal of the ogre, *Government* was sure to be misunderstood if someone said that he was laughing up his sleeve all the time.

The Ogre Ate Too Much

It seems funny now writing about those days because it seemed then that Blue Cross would win the battle. Later, when 26,000,000 people had joined Blue Cross to fight the ogre and 75 per cent of all the patients were "full pay," the results seemed less certain, not because of the ogre's appetite—that had long since been satisfied. Now so many people came to stay at the hospitals that the ogre became stupid, so sated that he never could be found anywhere—always off somewhere sleeping off his enormous intake.

Hospital superintendents said "poof" to him and meant it. Sometimes trustees of hospitals even sighed for the good old days when their friends weren't always at them to use their influence to get Aunt Mary a bed in a hospital or help Uncle Fred stay for one more day, even though the doctors said he was quite well enough to go home. The doctors complained too because their business had grown to such an extent that it was hard to get a day off—even an hour free from demands of patients wanting to go to the hospital. While it may be said that the increase in the hospital's paying patients was not solely the result of Blue Cross, still it is a remarkable coincidence that the increase in paying patients in most areas about equaled the percentage who were Blue Cross patients.

It was the same with nurses and employes. Even though the hospital

passed out much more of the lettuce to them than they'd ever had before, their work became heavier and many said that such burdensome duty as hospitals now required was even greater than ordinary places of work and ordinary places of work gave out more lettuce and why shouldn't they get more of it, too?

Seven headed dragons and other multimembered beasts have always caused trouble, of course, but never before had a single ogre set so many others in motion. Just as Blue Cross had about 26,000,000 people, all organized to fight *Hospital Occupancy,* another ogre appeared to plague hospital superintendents and trustees—his name was *Cost Accounting.*

Before, everybody from superintendent to employe had said if only more patients would come to visit the hospital, bringing the nice fresh lettuce the ogre adored, he'd be satisfied and not kill us, now, everybody was saying, Blue Cross has certainly made the ogre quiet; we even go around kicking him in the shins these days if we can find him. Of course, this is only temporary. What with the efficiency of the tax gatherer and the dying of donors, the desires of nurses and employes for more lettuce and the fact that *Government* brings so little lettuce for the patients he sends to the hospital, *Cost Accounting* requires that Blue Cross send us a lot more lettuce or this new ogre will push us to the wall, and his pal, *Government,* will take us over. Only this time *Government* is smarter than when he joined hands with that puny little ogre, *Hospital Occupancy.*

And so all the superintendents and the doctors, the trustees and donors, went scurrying again to find someone to help them fight *Cost Accounting* because *Cost Accounting* was a pal of *Government* and while *Government* wasn't bringing in enough lettuce he would just the same take over the hospitals.

Now *Cost Accounting* was a different kind of ogre from *Hospital Occupancy. Hospital Occupancy* lived everywhere and scared everyone, but after all he was a tangible ogre. He would show himself plainly and his demands were relatively easy to meet, if patients brought the lettuce to feed him.

Cost Accounting, on the other hand, was a less visible ogre. He would show himself in the minds of superintendents and trustees, only faintly at first.

And the Things He Said!

Usually he made his first appearance at midnight or after. He would say, "Of course, you are doing all right now, but these are war times and won't last. Your equipment is wearing out. Your buildings need repair. Since you can't hire the people you need to staff your hospital, you can't spend much lettuce for them. But times will change. You will be able to buy equipment soon and have your buildings repaired. Your employes will return from war."

And with an especially long needle he would jab the poor superintendents so that they could not sleep at all, adding, "What will you use for lettuce then?" He would only let the superintendents sleep after exacting a promise that tomorrow, sure, each superintendent would find out how much it cost to peel an Idaho potato in comparison with a Pennsylvania potato, or the square foot cost of the disinfectant used in scrubbing the operating room floor.

Of course, this was all *Cost Accounting* needed because once a superintendent and his auditing staff, the committee of the board of trustees and even the doctors got to figuring out such puzzles, they went on to others. Figuring out the per pound cost of flat laundry began to be great sport. Superintendents vied

with one another and the one with the lowest cost per pound was judged the best manager, though the losers usually consoled themselves by saying that if the winner had been as rigorous as they and included each and every item of cost, his per pound cost would have been the highest, not the lowest.

And there was more than a certain reasonableness in this argument, as there usually is, because analysis usually revealed the fact that the winner was free from the harassment of some of *Cost Accounting's* pals. If *Amortization,* for instance, was not exacting his due, or *Obsolescence,* or if the superintendent didn't know about these ogres, this placed him at a temporary advantage. When the trustees of other hospitals heard about the superior management of the superintendent with the lowest per pound cost of flat laundry, they made their own investigations, and this, of course, only served to expand the many-headed insidious ogre, *Cost Accounting,* even more.

He Brought His Friends

It was not long before *Cost Accounting, Amortization* and *Obsolescence* were joined by *Modern Bookkeeping, Machine Bookkeeping, Depreciation* and *Reserve Accounting* and such is the strength of these ogres that once established they could not be dislodged except by depression or some other disaster, like the sky falling down. You know how it was when Henny-Penny went around saying that the sky was falling down—how she met Turkey-Lurkey, who told Cockey-Lockey and all the other barnyard folk until everyone believed that the sky was falling down when, as it turned out, it was really just an apple that fell with a loud thud behind Henny-Penny.

So it was with *Cost Accounting.* What started out to be merely an exercise in determining the relative cost of peeling potatoes grew and grew. The way it grew and the rate the resulting misconceptions multiplied will, I am sure, keep many young scholars busy for years.

You can see the theses now: "Monograph on Recent Trends in the Per Forkful Waste of Feeding Patients in Hospitals of From 200 to 215 Beds"; "Monograph on the Per Pound Cost of Live Steam in Operation of Laundries in Hospitals Having 160 to 168 Beds in Urban Areas"; "Monograph on Time Consumed by Nurses Waiting for Water to Run Cold at Drinking Fountains in Hospitals Having 115 to 118 Beds," and so on.

Of course, each of these monographs calls for others for rural areas —Southeast as opposed to Northwest and various sized hospitals, not to mention Sponsorship and Control.

But there isn't time for all this now. These are only comments that scholars will later use as footnotes because of their general character. The truth is that *Hospital Occupancy* being satisfied, *Cost Accounting* started a whole new set of ogres by saying something like this, "Yes, it is true *Hospital Occupancy* is now satisfied, but his satisfaction is of the unthinking, brute sort—no vision. Suppose you do have lots of paying patients, actually hospitals cannot look to the future for five or fifty years without fear of being 'taken over.' " Of course, nobody else could either, but that didn't matter.

To clinch his argument, he quoted authorities. *Amortization* had told him this in strictest confidence. He had been told by *Obsolescence. Obsolescence* was told by *Modern Bookkeeping* who was told by *Reserve Accounting. Reserve Accounting* had it from *Depreciation* who had it from a Korean astrologer. The astrologer got it direct from the stars.

Of course, no one stopped to consider that while it was true that it took a lot more lettuce to run the hospital now than it did earlier, the hospital was getting a great deal more than it ever had and also that it was still the one type of business which received moral and financial support from *Community* and would always continue to receive such support.

As a result, hospital superintendents and trustees, doctors and nurses found it increasingly difficult to talk out of both sides of their mouths at the same time. You couldn't very well go on asking donors to give to hospitals when they died if while they were dying you dealt with them as though you were the owner of a hock shop. The prospective donors didn't think it was polite and the superintendents were embarrassed.

But the point of all this is that *Hospital Occupancy* and *Cost Accounting* and all the other ogres began to point not at the real problems at all but—just as at one time Blue Cross began to be talked of as the one thing that could save the hospitals from destruction, now suddenly and almost without warning Blue Cross began to be talked of as the one thing that threatened the very life of hospitals.

The footnotes on this transition are also very interesting. After *Cost Accounting* began to get its influence really felt, hospital superintendents went to Blue Cross and said, "We don't like the way you pay out the lettuce for your subscribers any more. Of course, we know you want to be fair to all hospitals and pay them all equally on an average basis, but our costs are not the same and neither are our charges. What we would like is for you to pay us the amount of lettuce we charge everybody, and let it go at that."

So the Blue Cross Obliged

Some parts of Blue Cross thought that was just fine because some hospitals only wanted a little bit of lettuce, and if they'd be satisfied with a little bit instead of an average amount, then those that complained the most could have all they wanted and keep their big mouths shut. And so in those communities Blue Cross did exactly what the hospitals wanted.

It was not long, of course, before those that were getting less than the others said, "Well, if other hospitals can get more and not do as good a job for patients as we do," and naturally everybody feels this to be true, "why can't we get more?" And Blue Cross started to get higher and higher demands for patients' lettuce, until what the patients put up was no longer sufficient to meet the demands of the hospitals.

In 1946 almost a third of the Blue Crosses were losing money on this account and Blue Cross began to use some of the same kind of double talk that *Cost Accounting* and *Reserve Accounting* and all the others had been using all along. One of the favorite methods of double talk resulted in an agreement by which Blue Cross would pay hospitals their costs or their charges, whichever was lower. In one area, the Blue Cross nearly busted using this device, and wherever it was used it caused trouble.

Next Blue Cross said, "We most assuredly have to help the hospitals

and we want to keep them happy. So let's pay their charges but with a ceiling." Of course, the ceiling moved from six leaves of lettuce a day to seven, and from seven to eight, to nine and then to 10 and even 12. Wherever it was used the results were the same, and so Blue Cross had to go to the patients and ask them for more of their lettuce in order that it could pay out more to the hospitals.

Nobody knows exactly how much the patients will be willing to give Blue Cross, but a lot of people have a pretty good idea and their guess is as follows: As soon as the demand for lettuce exceeds what the patients regard as reasonable, they will no longer pay their lettuce to Blue Cross, and . . . no one will know when that point has been reached until it has been passed. The problem, of course, is that patients can now go to the hospital without paying any lettuce and get all the care that they want without giving up any of the lettuce they need.

Doctors Like Lettuce, Too

The doctor won't like this because if the patient doesn't bring any lettuce to the hospital, he can't get any either. The patient doesn't want this because he wants to choose his doctor and be a private patient of his doctor even if his "semiprivate" room has six beds. The hospital will think this is terrible because *Government* is the only ogre that has enough lettuce to pick up the slack, and *Government* always wants to run everything even if he puts in just a little bit of the lettuce.

Most Blue Crosses are now paying the hospitals about eight and a half leaves of lettuce for every day of care, whereas in 1940 they were paying about six and a half leaves per day. In addition, the hospitals collect about one and a half leaves of lettuce per day from Blue Cross patients for private rooms and other extras, so hospitals now get about 10 leaves a day as opposed to eight in 1940. These amounts vary, of course, by areas as do the increased costs of hospital care.

While some Blue Crosses have raised their demands to subscribers the rest are sort of timid about going ahead on this though it will have to be done generally if the hospitals have to have more to satisfy all of the ogres.

Blue Cross, you see, remembers that even today when it has millions of subscribers and is getting more every day a large portion of its subscribers in the larger cities could get hospital service free—and while patients want to be on their own and have become convinced that this is a good idea, it's pretty hard to sell someone on the idea that he should pay very much of his lettuce for something he can get for nothing. Especially when it's a remote thing like hospital service which only seems good to people when they're not feeling well and, of course, most people feel good most of the time, otherwise things wouldn't run as well as they do.

In addition, Blue Cross has its ogres too. *Government* is one of them. *Insolvency* is another. It wouldn't help the hospitals very much if Blue Cross went on promising more than it could pay out because what the hospitals really want is protection against evil days. Then there are a host of others like *Commercial Insurance Competition* which gets smarter every year, not only in making a better product but also in wooing the hospitals and doctors by saying that *Service Contracts* of Blue Cross are the bunk because they put the hospital and doctors on the line to deliver what patients want but *Indemnity Contracts,* which it sells, would give patients only a limited amount of lettuce which the patients could use to pay the hospital and doctor.

The hospital and doctor under *Indemnity Contracts,* however, are permitted to charge patients all they want to in addition. *Indemnity Contracts* to Blue Cross is almost as bad an ogre as *Hospital Occupancy* was to the hospitals only it's subtler because the hospitals and doctors are led into hoping they can have their cake and eat it too and, of course, that's a very nice kind of business if you can get it.

Blue Cross has other problems, too, like the union benevolent societies that are springing up to run their own clinics and hospitals, and it's really surprising how low the premiums of some of these organizations can be because they select their risks very carefully which Blue Cross can't do—that wouldn't be fair to *Community*—and they don't have to give free care like the hospitals and doctors, and also because the unions are pretty efficient in running their clinics and hospitals, not being plagued by ogres because they never heard of them.

Also, they get contracts with employers, like John Lewis did, which pay a certain percentage of all the lettuce a business takes in, or a percentage of the pay roll, like the leather workers, the knitting mill workers, the clothing workers and dozens of other groups. In fact, sometimes poor Blue Cross gets groggy from the pummeling it takes from all sides and wonders whether it's worth the candle.

Patients like Blue Cross and are quick to say so. The usual comment about Blue Cross from patients is, "That's a good outfit. It pays." And this is the most important thing to everybody because if the patients won't pay their lettuce, there won't be anything for anyone.

No Wonder Blue Cross Shivers

Every once in a while now, Blue Cross starts thinking about the story of the Goose That Laid the Golden Egg. You remember how that was, of course, and it makes the shivers go up and down its spine because nobody likes to have his neck lopped off especially if he knows in advance that no good will come of it.

And, that's the way I have to leave this story—with Blue Cross shivering but going right on with its job as though the ogre that bothered hospitals and hospital superintendents, doctors and nurses, trustees, hospital employes and all the children were not egging them on to kill the nice fat goose, Blue Cross, to see what his insides are made of. Of course, if all the patients and the newspapers and the radio stations got the true facts about what Blue Cross has made possible for hospitals and doctors, it might give hospital superintendents courage to say "poof" to all the new ogres, just like they do to that puny ogre *Hospital Occupancy,* and when you think of it—that's just what ought to be done.

IT HAS long been felt that the closer together a medical school and its teaching hospital can be built the better the entire functioning plant will be. Heartily endorsing this dictum, the University of Alabama recently had the opportunity of seeing just how closely a medical school and its teaching hospital could be physically integrated and just how well they could function together with this close relationship.

Following a period of eighteen months, during which time a temporary close integration of the Medical College of Alabama and its teaching hospital existed as a result of the installation of the medical college on vacant floors of the hospital, a final plan for the construction of the medical college building was agreed upon. The integration of the two was so successful during this period that it was decided to further this idea by constructing the new medical college as an addition in the form of two wings, one on each side of the teaching hospital. The final result will have the teaching hospital located in the center of the medical college, completing physical and professional integration.

Medical College Moved

In 1945 the first two years of the Medical College of Alabama were moved to Birmingham from Tuscaloosa, and the last two years of the course were organized and put into operation. Partly through necessity and partly through design, Dean Roy R. Kracke of the Medical College of Alabama accepted three vacant floors of the Jefferson Hospital as a temporary location for the medical school. Even though funds were appropriated for the construction of a new medical college building the uncertainty of all building programs delayed its construction.

The Medical College of Alabama continued in operation, therefore, on the vacant floors of the Jefferson Hospital for more than eighteen months, and the purpose of this article is to explain how well it has functioned within its teaching hospital and to describe the plan for the construction of the new Medical College building.

The training of medical students and the medical service to patients in the hospital have been so closely associated in every department that it is necessary to follow the development step by step, beginning with each department as it was established.

The first faculty appointment made by Dean Kracke was that of Dr. Roger D. Baker, professor of pathology. Dr. Baker organized his department with full time personnel, and the department was housed on a portion of the vacant sixth floor of Jefferson Hospital. Complete pathological laboratories and new necropsy rooms were installed. This department assumed full responsibility for all the pathology service for both charity and private patients, all postmortem examinations, gross surgical descriptions and tissue examinations.

In addition, a complete embalming service was instituted under the supervision of Dr. Baker, which greatly improved the hospital's relationship with undertakers and assisted materially in increasing the percentage of necropsies obtained. During the first year of the department's operation, Dr. Baker also advocated the elimination of the coroner system and hopes to replace it with the medical examiners' system throughout the state.

In the department of clinical pathology and bacteriology, Dr. William H. Riser was appointed to the faculty of the medical school in the position of associate professor of clinical pathology and director of laboratories. Dr. Riser assumed responsibility for the operation of the general laboratories of the hospital and members of his staff organized a hematological laboratory, a new blood bank and the laboratories for the instruction of medical students, student nurses and student technicians.

The general laboratories are located in Jefferson Hospital and the new laboratories were built in a section of the Hillman Hospital that was left vacant when all charity patients in Hillman were removed to vacant floors in Jefferson Hospital. The new blood bank occupies a portion of the older operating rooms on the seventh floor of Hillman Hospital. Therefore, in three locations within the hospital, the clinical labo-

Experiment in Integration

Medical College and Teaching Hospital Function as One

J. W. MACQUEEN, M.D.
Administrator, Jefferson-Hillman Hospital, Birmingham, Ala.

ratory work of the hospital, a blood bank, a hematological laboratory and the instruction of three types of students were begun.

The department of physiology and pharmacology is housed on the fourteenth floor of Jefferson Hospital. Dr. John M. Bruhn, professor of physiology and pharmacology, supervises and directs the work of the heart station and basal metabolic laboratories.

The hospital pharmacy was integrated with the medical school when it was placed under the direction of Dr. Robert S. Teague, associate professor of physiology and pharmacology, who has full responsibility for the hospital pharmacy.

As the preclinical departments were moved from Tuscaloosa to Birmingham they were housed in space on the sixth floor not occupied by the department of pathology and on the fourteenth and seventeenth floors of the Jefferson Hospital. The department of anatomy was housed on the seventeenth floor with new dissecting rooms, lecture rooms and laboratories. Bacteriology, pharmacology and physiology, with their laboratories, were placed on the fourteenth floor.

On the remainder of the sixth floor of Jefferson Hospital and extending over into the sixth floor of the old Hillman Hospital, the new medical college library was located. This combined the libraries of the Jefferson County Medical Society, the Medical College of Alabama at Tuscaloosa and the Jefferson and Hillman hospitals. At present, it has approximately 20,000 volumes and subscribes to more than 300 medical and allied scientific publications.

On the remainder of the sixth floor in the old Hillman Hospital, suites of offices were constructed for the full time clinical faculty members and their secretaries. Large lecture rooms were located on the sixth floor of Jefferson Hospital and on the sec-

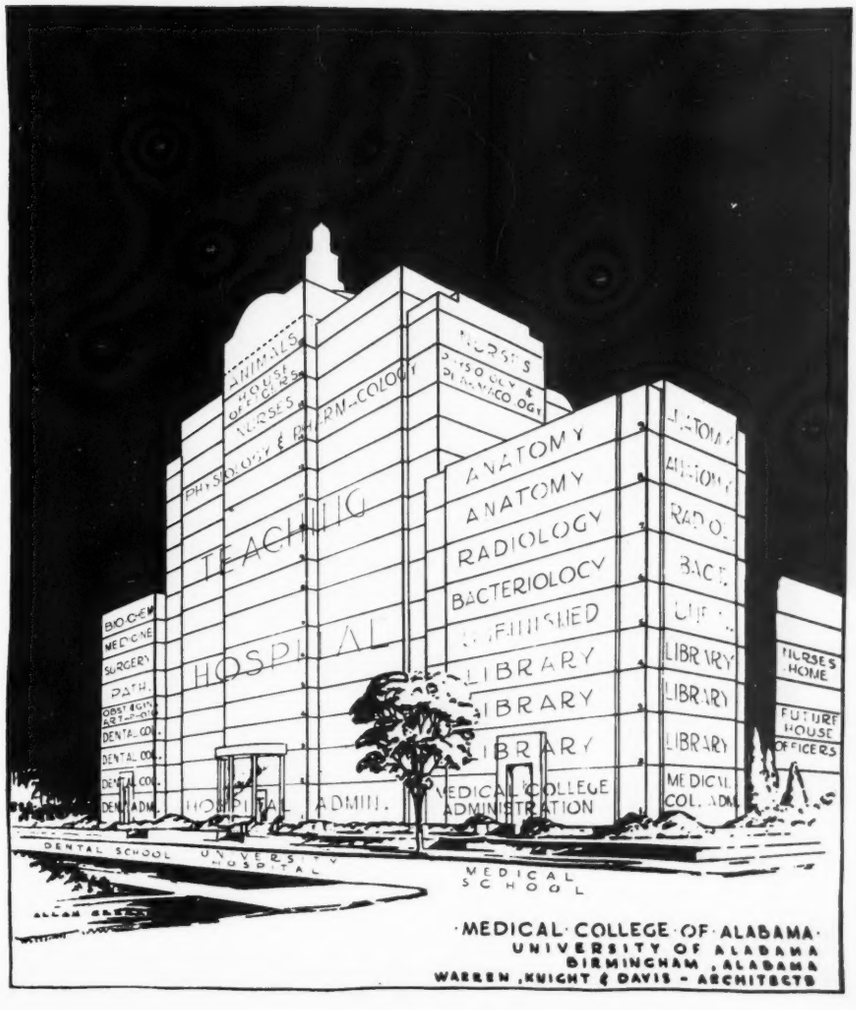
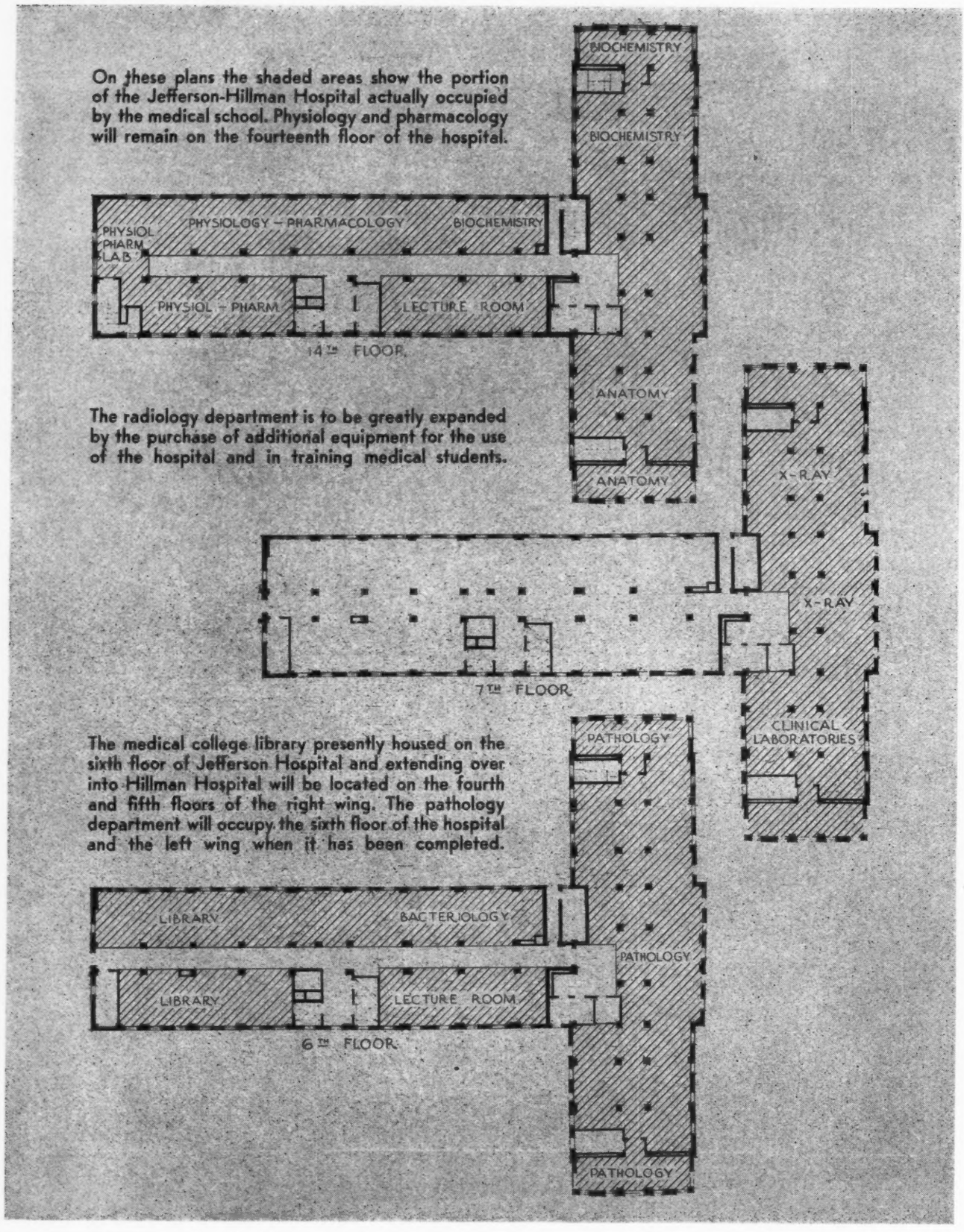


Diagram of the proposed structure to house the Medical College of Alabama with the teaching hospital in the center and the two wings of the medical school on either side. Warren, Knight and Davis of Birmingham are the architects.



ond floor of the outpatient building. Each department of the outpatient clinic has been integrated with that department of the medical school and is under the direct supervision of the chief of service of that department of the faculty.

Later, Dr. Melson Barfield-Carter was appointed associate professor of surgery in radiology on the faculty of the medical school. She directs the work of the radiological department of the hospital and assumes full responsibility for all services to the patient required of this department.

This department still occupies its previous location on the seventh floor of Jefferson Hospital and is to be greatly expanded by purchases of additional equipment by the medical school for the use of the hospital and in training medical students as well as student radiologists.

Dr. Allison E. Imler was appointed associate professor of radiology and director of the tumor

clinic on the faculty of the medical school. He has charge of all x-ray and radium therapy in the hospital and the outpatient department. All cases of suspected malignancy are referred to the tumor clinic where, following extensive diagnostic procedures by Dr. Imler and his staff, therapy is given these cases with the usual deep x-ray therapy equipment and 200 mg. of radium previously owned by the Jefferson-Hillman Hospital.

On the first floor of the vacated Hillman Hospital, the offices of the dean, the business office of the medical college and a student cafeteria have been installed.

The Jefferson County Health Department has been located in the remaining space left vacant in Hillman Hospital when the patients were transferred to Jefferson. This gives the health department close contact with both the medical school and the hospital.

Anesthesiologist Appointed

The most recent addition to the faculty of the medical school has been the appointment of Dr. Alice McNeal as associate professor of surgery in anesthesiology. Dr. McNeal is in charge of the department of anesthesia of the hospital and will have full responsibility in the appointment and assignment of her staff of anesthetists and for a training program in anesthesia.

With close cooperation between the administrator of the hospital and the dean of the medical school, this professional fusion of the medical school and its teaching hospital has been brought about to the mutual advantage of both. Full time chiefs of all the departments of the hospital on the faculty of the medical school assure the patients of the hospital the best possible care and unlimited diagnostic procedures.

Although a portion of the benefit of this close association between the medical school and the hospital may seem intangible, it becomes very real in actual operation. Service in the hospital has improved remarkably and has functioned smoothly without conflict, even though a part of the staff that attends private cases in Jefferson Hospital has no appointment on the medical school faculty for the present.

All the departments of the hospital are maintained with a high level of competence. All the patients in the hospital receive adequate care on an advanced level because of certain services the medical school supplies which the hospital alone could not achieve. A close combination of the hospital and the medical school represents many advantages and no disadvantages.

With the medical school developing rapidly during the last year, the improvement in hospital service to the patient because of this close relationship has taken place to such an extent that some have wondered if this condition of improved service would continue if a separate building for the medical college was finally decided upon. The final plan to construct the medical college building as an addition to the hospital, therefore, was approved to assure the continuation of the advantage of close integration.

In the accompanying drawings of Jefferson Hospital, the additions to the hospital building are the two wings on the sides. In the second drawing, the location of the various departments of the medical school are shown in the two wings and in the main portion of the lower floors of the hospital. The major idea of the plan is to place the departments of the medical college in the two wings and let them extend, if necessary, entirely across the hospital between the two additions, moving patients from lower to higher floors in the hospital building proper.

The entire ground floor of the hospital building will be assigned to administrative offices of both the hospital and the medical college. The floors in the wing on the right facing the hospital will contain the preclinical departments, such as anatomy, biochemistry, bacteriology and the library. Physiology and pharmacology will remain on the fourteenth floor of the hospital. In the addition to the left facing the hospital, three floors will be devoted to a new dental college, and the remaining floors, to clinical departments of the medical college, such as surgery, gynecology and obstetrics and medicine. The patients' areas in the main hospital building will be moved above the fifth floor. The obstetrical and gynecological departments of the hospital are at present located on the fifth floor and will remain there. The pathology department will occupy the sixth floor of the hospital and the left wing. The operating rooms are at present located on the seventh floor; the department of surgery will occupy the left wing with the x-ray department extended into the top floor of the right wing.

In addition to these changes in the main hospital building, the outpatient clinic is to be connected to the main hospital building on each floor, and the corresponding departments in the outpatient department will be on the same floor as the corresponding department of the hospital, that is, medicine on the fourth floor of the hospital and the fourth floor of the outpatient department; obstetrics and gynecology on the fifth floor of the outpatient department and on the fifth floor of the hospital; surgery on the seventh floor of the hospital and on the seventh floor of the outpatient department.

There Is Room for Expansion

The space evacuated in the old Hillman Hospital which joins the rear of Jefferson Hospital will remain as room for expansion by any of the departments located from the seventh floor down. At present, the operating rooms on the seventh floor of Jefferson can extend into the old operating rooms on the seventh floor of Hillman if additional operating rooms are needed. The department of obstetrics on the fifth floor of Jefferson has already extended into the fifth floor of the old Hillman for much needed additional space. The pathological laboratories can extend into the sixth floor of the old Hillman Hospital if additional room is needed.

This plan of building the medical college as additional wings to the hospital is designed simply to facilitate the present professional integration between the two by adding actual physical integration of the hospital and medical school. The importance of this plan seems to be that in the future construction of medical colleges and their teaching hospitals this close physical integration will lead to a new type of hospital and medical college construction.

We feel that the present plan has successfully accomplished this integration even in previously existing buildings. In new construction, with this idea in mind, more exact integration can be planned with the final design resulting in a medical college and its teaching hospital being built as a single unit.

MEN AT WORK on Better Hospitals for Everybody

VANE M. HOGE, M.D.

ROBERT M. CUNNINGHAM JR.

SPEAKERS and writers who warn on a rising note of alarm that we have to keep the federal government out of the hospital business are approximately 150 years too late. The federal government has been in the hospital business since 1798, when, during the administration of John Adams, the Congress passed an act providing for "the relief of sick and disabled seamen."

Except for the federal money paid to hospitals under the Lanham and Bolton acts during the recent war, however, the government's interest in hospitals was pretty well limited to institutions caring for merchant seamen and members of the armed services—until last year.

Hill-Burton Act Starts New Era

The Hill-Burton Act, signed by President Truman August 13, introduced a new era in government-hospital relations. With $75,000,000 a year to spend on hospital construction for the next five years, the government is in the hospital business with both feet today. The few who are a little troubled about the implications of this new relationship are fairly evenly divided between hard headed observers who think everything the government has anything to do with is automatically bad and scholars of ancient history who recall uneasily that increasing dependence upon government aid was one of the early symptoms of degenerative disease in the civilizations of Greece and Rome. Everybody else thinks it's fine.

The government was not unprepared for the heavy hospital responsibilities thrust upon it by act of Congress last summer. In 1941 the hospital facilities section was organized under the Bureau of State Services in the U. S. Public Health Service for the purpose of certifying to the necessity of hospitals and health centers constructed under the Community Facilities Act, or Lanham Act, as it was known to hospitals faced with burgeoning defense industry populations and desperately seeking funds for expansion.

Significantly, the men around whom the section was organized then were Dr. Vane M. Hoge, now chief of the Division of Hospital Facilities, which is administering the new program, and Marshall Shaffer, the division's chief architect today.

In addition to screening specific hospital projects for war industry centers and planning construction so as to use a minimum of critical materials, the section offered technical consultation services in hospital and health center planning to the War Department, the War Production Board, the Federal Works Agency, the Office of Inter-American Affairs and several foreign governments. Little by little, these services were expanded to include consultation on administrative procedures, equipment problems and population surveys, as well as specific project plans.

When, in late 1944 and early 1945, postwar planning began to supersede war emergency measures as the nation's principal preoccupation, the hospital facilities section joined forces with the voluntary Commission on Hospital Care in the general survey of national hospital needs which has recently been published. The Hospital Survey and Construction Act began to take shape early in this period. Its passage last summer found the Division of Hospital Facilities organized for action.

While the Hospital Construction Act was thus the culmination of some two or three years of planning, the man who is its chief administrator started training for his job 12 years ago. A graduate of Jefferson Medical College in Philadelphia, Dr. Hoge, now 45 years old, interned at the Marine Hospital on Staten Island and became a commissioned officer of the Public Health Service within a year after graduation.

They Had to Be Versatile

At that time, there were few specialists in any phase of public health medicine on the U.S.P.H.S. staff; the theory was rather that every commissioned officer should be experienced in and ready to accept any assignment in the public health book. The average officer might spend a year or two each, for example, in venereal disease control, clinical tuberculosis, hospital administration, malaria research, customs inspection and food sanitation, among other things, changing character from job to job like a Hollywood extra between scenes.

This method of operation has been largely discarded today, and Dr.

Hoge was among the first of the commissioned corps to become grooved comparatively early in his career. After a couple of years in the consular service and a turn at research in the Rickettsial diseases, during which he published several recondite papers on the incidence of psittacosis in the United States, Dr. Hoge was tapped by the surgeon general to attend the graduate school of hospital administration which had just been organized at the University of Chicago. He finished this course with the master's degree in 1936 and spent the next five years as rural hospital consultant with the National Institute of Health, a branch of the Public Health Service.

No Yes-Men Need Apply

While he might, technically, be classified as a bureaucrat, Dr. Hoge is completely atypical. He is hard working and quiet spoken, approaching his job more as student than as master, surrounding himself with the best technical and professional brains he can get instead of the eager yes-men who make up the classical picture of a bureaucrat and his stooges.

Least of all does Dr. Hoge typify the common concept of bureaucracy in the way he thinks about his office and its function. "This is the states' program," is the way he describes it. "We can't run it from Washington, and we don't want to. Instead, the states are going to make and follow through on their own plans. Of course, we'll give all the help we can from here and from the district offices we have established, but the program begins and ends with the state planning boards."

Frequently, this kind of talk on the part of government officials and others is simply a conversational cover for an absorbing ambition to run the whole show. That this isn't the case with Dr. Hoge is amply demonstrated in his insistence that leading hospital authorities be consulted at every possible point. He was foremost among those who held out for a law that would set up the predominantly nongovernmental Federal Hospital Council and its advisory committee of technical experts. As he administers the law, these experts, rather than Hoge and his staff alone, are writing the rules.

As Dr. Hoge explains it, the functions of the Washington staff will be to approve uniform standards for hospital planning and construction, so that federal funds may not be applied to inadequate plans or substandard projects; to review specific plans to make certain that they meet the stated requirements, and to provide consulting services and conduct research in every phase of hospital planning, design, construction and operation.

To keep abreast of standards as they were being developed, and now to follow the progress of hospital survey and planning groups in the various states and to outline research and consulting services, Dr. Hoge holds frequent meetings with the growing division staff in his large, barren office in the Railroad Retirement Building, where, it is rumored periodically around Washington, the widely scattered offices and activities of the Public Health Service may ultimately be concentrated. Such meetings are interrupted from time to time by telephone calls from congressmen who know there is federal money for hospital construction and also know that hospitals are badly needed back home in Arkansas or Montana.

Dr. Hoge answers these calls himself, explaining carefully that the money will be spent on the basis of professional surveys and giving congressmen the names of the people, back home in Arkansas or Montana, who are making these surveys.

MARSHALL SHAFFER J. R. McGIBONY, M.D.

In a huge, airy penthouse atop the Social Security Building, across the street from Dr. Hoge's office, a tightly knit little group of architects and engineers has been working around the clock since August 13, wrestling out of their drawing boards and tables of specifications the future shape of the nation's hospitals. Here the construction standards, now enshrined in massive manuals, were written, revised and rewritten, time and again. Here final architectural plans for the billion dollars' worth of new hospitals and health centers that are going to be built with federal aid must stand inspection, after preliminary routing through state boards and architects and district division offices. Here is the technical nerve center of the whole vast hospital and health center construction program. Here, as the program's presiding technical genius, is Marshall Shaffer.

He Seeks to Make Converts

The worried, distracted look which Shaffer habitually wears probably derives from the fact that there are millions of people in the world who do not yet share his passion for modern architecture. Until everybody is converted to his views, Shaffer will always feel the restless urge of a man whose work is only half done. The other, or finished, half of Shaffer's career makes an impressive record.

After his graduation from Penn State College in 1922, Shaffer spent three years as an engineer in Central America, then returned to study and practice architecture in Southern California, where he worked with Richard Neutra, at that time a recent arrival from Europe's progressive architectural circles. Shaffer came back East in 1930 to practice, study and teach in Chicago and New York.

During this period he won several architectural competitions and attended an International Congress on Modern Architecture in Athens. In 1938 he went to Washington, where he served as architect for several government offices, including the Federal Works Agency, winding up with Dr. Hoge in the original hospital facilities section.

Running the technical services office of the present division is more of a religion than a job for Shaffer, who thinks about hospital planning the way G.I's on lonely Pacific islands during the war thought about Main Street and apple pie. To him, proper consideration of hospital functions in design and inclusion of qualified architects on hospital planning boards are problems scarcely less important than the control of atomic energy.

Shaffer's headquarters is an old oak desk tucked away in a corner of the penthouse drafting room, but he rarely sits still for more than a few seconds at a time. His days in the office consist almost wholly of urgent trips up and down the room to inspect work in progress on drafting boards and hold impromptu conferences in the aisles with his assistants and any visitors who happen to be around.

While he runs up some terrific mileage in the process, Shaffer is thus able to keep his entire staff keyed to an intensity which compares favorably with his own. Like Dr. Hoge, he travels around the country carrying the word to assorted groups of architects, hospital administrators, government officials and others who can help in any way to make better planned hospitals a reality.

Like Hoge, too, Shaffer breaks out in all directions from the ordinary view of bureaucracy. He calls on outsiders constantly for opinions and advice, so that finished work coming from his office actually represents not his thinking only, nor his staff's, but the whole country's.

Shaffer is in government work today because it is there, he feels, that he can cover the most ground and expose the most people to his architectural credo. Like the fabled musicians of Laputa, he has one all-consuming interest; his unconcern for everything else is total.

This is the first of two articles about the Division of Hospital Facilities. The second article will appear next month.—Ed.

Use Is the Ultimate Test of *Good* Medical Records

SISTER M. PATRICIA, O.S.B.
Administrator
St. Mary's Hospital
Duluth, Minn.

IT MAY be said that the functions of the medical record library are three: (1) to obtain medical records; (2) to preserve medical records; (3) to use medical records. Out of these three functions grow all the duties of the record librarian and the technics she employs.

We may ask, "What is required in a record library for carrying on these functions?" The American College of Surgeons' "Manual of Hospital Standardization" outlines six "basic requirements for an efficient department of medical records."

1. There must be a medical record library and equipment.
2. There must be efficient personnel.
3. There must be a plan to obtain medical records.
4. There must be supervision of medical records.
5. There must be sufficient files and cross indexes.
6. There must be a monthly report prepared.

The remainder of this discussion will be devoted to a consideration of the relationships between the three functions of the record library and these six requirements.

Let us consider the first function: Obtaining medical records should always be expanded to mean obtaining *good* medical records. Here, location and equipment of the record library play important rôles. The best location will depend upon many points peculiar to the hospital in question, but it is almost a principle to say that accessibility to the medical staff is the deciding factor in all situations.

Equipment, too, will vary with the size and type of hospital, but there must be a place for the doctors to work. This may be only a table or desk, depending upon the size of the staff, but it must be theirs. No doctor likes to displace a record librarian or clerk each time he would complete a record or use one. In my opinion, no other single factor so militates against obtaining good medical records as does the lack of proper facilities for the doctors in the record library.

The record librarian's own rôle in this function is limited. Her direct contribution, however, is twofold. First, she should know the standards which have been set so that she can advise others. Chief among these standards might be cited the definition of a medical record from the "Manual of Hospital Standardization."

This definition reads: "The medical record is an orderly, written re-

From a paper presented to the institute on hospital administration sponsored by the Manitoba Hospital Association, October 1946.

port of the patient's complaint, history, physical examination, diagnostic findings, treatment and final results. . . ." The manual goes on to say that the "record is further supported by the necessary identification data, social history, and nurses' notes." Another standard the record librarian should know is the criterion for a good medical record, which has been laid down as "sufficient data written in sequence of events to justify the diagnosis and warrant the treatment and end results."

As her second contribution to obtaining good medical records, the librarian should be able to render needed secretarial help to the medical staff when there is no other person in the organization to perform this duty. A word of caution here, however: it is poor economy to use a registered medical record librarian for routine stenographic services when such work means neglect of the duties which only she can perform.

Greatest Contribution Indirect

The record librarian's greatest contribution to obtaining good medical records is indirect. This lies in stimulating medical record consciousness in the hospital. In this respect she cooperates with all department heads, as well as with the administrator and medical staff. She can go only so far, however, as the hospital policies permit. The job of obtaining good medical records cannot be performed by any one person even though that person has been especially trained for that duty.

Two of the basic requirements for an efficient system of medical records have a bearing on this function of obtaining them. One requirement suggests that the hospital have a definite plan. The plans suggested are merely the writing of records by the physician himself, by the interns, by dictation to a stenographer or to a dictating machine. Only the last of these plans needs elaboration here.

Dictating machines are becoming extremely popular and deservedly so. They save the time of both physician and record librarian and they make it possible to provide a twenty-four hour stenographic service. If the hospital has a dictating machine, the doctor can complete records whenever he has the time and the will to do so. That may be in the middle of the night while waiting for an obstetrical case or on a Sunday morning, but the machine will be there.

Another requirement for an efficient system of medical records is adequate supervision, *i.e.* in obtaining good medical records. The first step is taken by the attending physician who reviews and signs his own record. The second step falls to the record librarian who assembles the record in correct order, fastens it together and analyzes it for any quantitative deficiencies, such as missing signatures and missing reports.

The final step in appraisal is the responsibility of the medical record committee. This group is a standing committee of the medical staff charged with the responsibility of the qualitative appraisal of the medical records. This committee may be composed of the chiefs of the various clinical services, or it may be made up of from three to five members of the medical staff appointed by the chief to serve for a specified period of time. An active medical record committee can be one of the greatest stimulants to good record keeping that a hospital can have.

The second function of the medical record library, following naturally after obtaining good medical records, is the preservation of these records. The fourth clause of the A.C.S. minimum standard says that records must be filed in an "accessible manner." The accent is always on "accessible." One of the six basic requirements, consequently, are files and cross indexes.

The filing system for the medical records will vary from hospital to hospital, but the following systems are recognized:

Records may be filed alphabetically by the patient's name. This practice is not usually recommended, but it may be satisfactory in a small hospital.

Records may be filed by diagnosis or by the code number assigned to the diagnosis according to a nomenclature of disease. This practice has its greatest utility in a large hospital in which extensive research is done. Leading medical record librarians do not recommend it for the average hospital.

The most satisfactory method of filing medical records and the one most widely used is filing by the number assigned to the patient as his hospital identification. This number may be a serial one. Under serial numbering, the patient is given a new number each time he returns to the hospital. His earlier records may or may not be brought forward under the latest number. Serial numbering is usually recommended for a hospital which serves a transient population or which, for any other reason, has a low ratio of readmissions.

The other type of numbering is unit numbering. Under this system, the patient receives a case number upon his first admission to the hospital and retains that number on all subsequent admissions. As a result, all hospital records are filed in the one spot under the same number. Unit numbering makes all the files active inasmuch as a patient with one of the first numbers issued may be readmitted today and all his records may be reactivated. Unit numbering is usually recommended for a hospital serving a stable population and for one in which the medical staff uses the records for study. Incidentally, having all the patients' records filed under a unit number stimulates use of the records.

Indexes Are the Keys

Now, it is not enough to get the records filed, they must be accessible. We must be able to get them back out of the files for any of the purposes for which medical records are kept. Indexes are the keys that make the records and their contents accessible. The "Manual of Hospital Standardization" lists four indexes to be kept in the approved record library and we shall consider them in order.

First, there is the patients' index, often called the "name file" or the "master file." This is usually a card file containing the necessary identification of the patient as an individual (the sociological data) and as a hospital case (case number). Cards in this file are kept in alphabetical order or by some phonetic system. The patients' index is the key used whenever the record is needed for the good of the patient or whenever the person seeking to use the record knows the patient's name.

The second index to be mentioned is the physicians' index. This may be either a card file or a ledger index. Its purpose is to provide a record of the quantity and quality of the work done by the members of the medical

staff. This index is used whenever records are needed purely from the point of view of the individual physician. Dr. T. R. Ponton has devised an elaborate system of professional accounting (see his "Medical Staff in the Hospital") which makes extensive use of this index. Unless this system is followed, however, the physicians' index is the least used of all the required indexes.

Third is the diagnostic index or cross index of diseases. This is a "means by which the records of all patients for whom a stated diagnosis has been recorded are made available for study." (MacEachern's "Medical Records in the Hospital," p. 216.) We use the disease index whenever a record is needed from the standpoint of diagnosis without reference to the name of any patient. The equipment in which this index is kept is immaterial. It may be ledger, vertical card file or visible card, although each has its advantages in a particular situation.

Medical Staff Must Help

What is essential to good cross indexing of disease is the choice of a nomenclature of disease which the medical staff will follow in recording diagnoses. The only nomenclature of disease now available in an up to date edition is the "Standard Nomenclature of Disease" published by the American Medical Association. No record librarian, however, can use the Standard Nomenclature without cooperation of the medical staff; but, given that cooperation, she can do a much better job of cross indexing than is possible with any other nomenclature. Consequently, scientific uses of medical records will be greatly stimulated.

The last index mentioned in the manual is the index of operations. This parallels the index of disease in that it makes the records available for study when they are requested from the point of view of operations performed. What was said before about equipment for the index of diagnoses applies with equal force to the index of operations. Likewise, maintaining an index of operations presupposes the choice of a nomenclature of operations by the medical staff. The most authoritative nomenclature of this kind now available is that published by the American Medical Association in the same volume as the "Standard Nomenclature of Disease." The record librarian can use this nomenclature with a minimum of cooperation from the medical staff. Before it is installed, however, the surgical staff should realize its obligation to abide by its terminology.

The subject of indexes leads us into the all important question of uses of medical records. Although the fourth clause does not expressly mention "use" of medical records, the phrase "file in an accessible manner" implies it surely. In the "Requirements for an Efficient System of Medical Records" the only use mentioned is the making of a monthly report. The many other uses are discussed, however, in other pages of the manual.

By the monthly report here mentioned is meant the medical audit of hospital service. This report is based on the data contained in the records of patients discharged during the preceding month. It is called an "audit" because it is designed to bring out the credits and debits of the hospital service. The credit items are patients recovered or improved. The debit items are patients unimproved or died, and also the hospital infections. The means taken to check losses are necropsies and consultations.

All hospitals use their records to make this monthly report or audit, but it is the perpetual heartache of most record librarians that their records are not used in the many other ways possible. Use is the ultimate test of the medical record; only if it is used will we know if it is a good record. The more records are used, the more they are appreciated and, consequently, the better they will be kept. In the well balanced record library, about one half of the time should be spent in duties pertaining to obtaining and preserving medical records and the other half to using them or stimulating their use. This proportion cannot be kept if the record librarian is overloaded with clerical and stenographic duties which leave her no time for making statistical studies or assisting doctors with group studies of disease.

Stimulating the scientific uses of medical records will pay dividends in any hospital organization. Staff meeting programs will be better because they will grow out of a personal interest of the members in their practice of medicine. Cooperation among the members of the staff will be greater as they use one another's records in a common cause. The quality of medical practice will rise as a result of mutual constructive criticism brought out in group studies of disease. All of these advantages would be cheaply bought at the cost of more clerical and stenographic help for the record librarian, freeing her to do the specialized work only she can do.

The hospital administrator should know what is expected of a well functioning record library and see that the status of affairs therein is satisfactory. He should realize that medical record keeping is a cooperative venture, that the record librarian cannot do it all and that the medical staff should formulate rules and policies binding its own members to do their part.

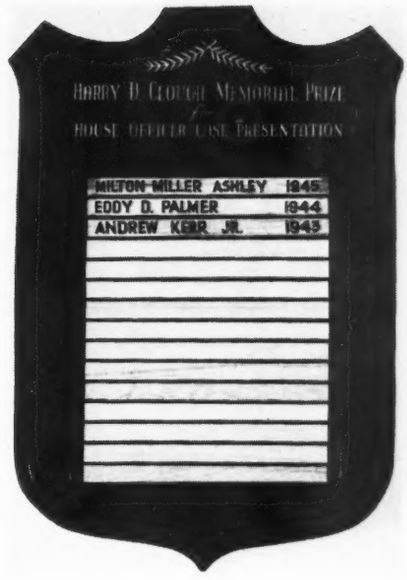
The Creamed-Chicken-and-Green-Pea Circuit

The Creamed-Chicken-and-Green-Pea Circuit
It's tough life for those who work it.
It's not the trains; it's not the traveling;
It's not the nerve-ends, frayed and raveling
It's the creamed chicken, the CREAMED CHICKEN
That makes the waistline swell and thicken.
It's the creamed chicken in the bird's-nest patty,
Oozing starches, rich and fatty.
It's the pallid cream sauce, wan and gooey,
With weary chicken, tough and chewy,
It tastes like buzzard or dead seagull,
It might be a shopworn moulting eagle.
Drowned in goop that tastes like mucilage,
Flavored with oil from a rusty fusilage.
You can't escape it—the Club Luncheon
With creamed chicken for you to munch on.
It's not the work that makes us sicken,
It's the blank-blank-blank-blank
Creamed Chicken.

—Don Blanding.

AWARDS

Are Rewarding
to Hospital and Staff



FRANK C. SUTTON, M.D.
Medical Director
Rochester General Hospital
Rochester, N. Y.

DESPITE the demonstrated value of educational awards, their advantages are not universally recognized. Many hospital administrators continue to dismiss the suggestion that awards be established with the comment that they are unnecessary or undesirable. It is hoped that those who remain skeptical of their value will find the following experience and resulting suggestions of interest.

Until recently, unconvinced of the need of educational awards in the hospital, I, in common with many others, felt that inducements other than achievement of high scholarship were unnecessary for interns, student nurses and students in schools for laboratory and x-ray technicians, dietitians and medical record librarians. The unexpected proposal of a house officer award offered anonymously by a member of the medical staff provided an opportunity to test the claims made for educational awards.

Result Was Convincing

The resulting award, known as the Harry D. Clough Memorial Award in memory of the late assistant medical director, is granted to the house officer who demonstrates the greatest interest in clinical conferences and who delivers the best case presentations in conferences during each year. The award, including a gift of $25, is presented in a brief ceremony at a medical staff conference at which the winner's name is placed upon a plaque hung permanently in the staff conference room. The popularity of this award (now in its third year) and the resulting marked improvement of case presentations by house officers leave no doubt as to its effectiveness.

It has become apparent also that the principal appeal of this award lies in the recognition which its presentation before a large group of physicians and fellow interns provides, and in the honor associated with the winner's name being placed upon a permanent plaque. The gift of $25, although welcome, is definitely regarded of secondary importance and would not, in itself, be expected to produce the same favorable results.

The success of the award for house officers resulted in another member of the medical staff creating anonymously a similar award "for the student nurse demonstrating the best ability in the field of general surgical nursing." This award also includes a gift of $25. Realizing the importance of adequate recognition, we arranged a simple but impressive ceremony for presentation of this award, which includes a surprise announcement of the winner at a special meeting of the entire class, a gift of flowers and presentation of the award in the form of a certificate mounted in a handsome case. This award (now in its second year) provides a new incentive with resulting increased interest in surgical nursing technic.

Another award recently established provides similar recognition of the student nurse whose essay on the importance of medical social service to nursing reveals the greatest insight into the relation between these two important fields of work. This educational award, known as the "Madge Loranger Memorial Award," was created by voluntary contributions of hospital personnel, medical staff and other friends of the late Madge Loranger, former head of the social service department of the hospital.

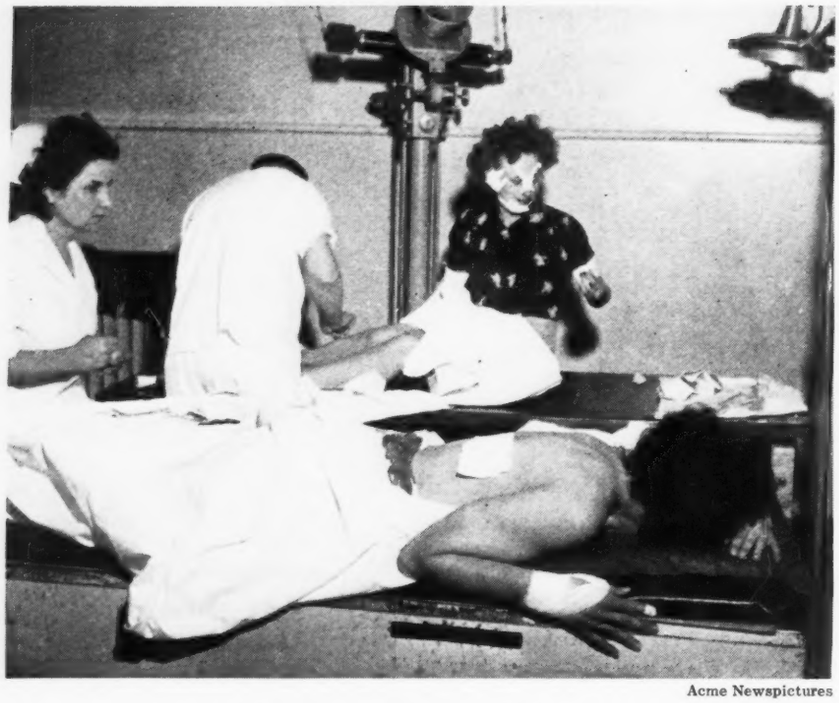
Under consideration at present is an award for the intern whose medical records from a qualitative as well as a quantitative standpoint are judged best by the medical record committee of the medical staff.

Try the Positive Approach

The best way to demonstrate the effectiveness of an award is to establish one in some phase of training in which student performance is consistently below acceptable standards. Instead of attempting to solve the problem by the negative action of penalizing poor performance, why not try the positive approach of rewarding exceptional performance?

Many opportunities exist in the average hospital to test the value of educational awards of various types. In the broad sense all hospital employes are participating in a continuous educational program — or should be. From a public relations as well as an employe relations standpoint, would it not be worthwhile to consider offering awards for employe courtesy, suggestions for improvement of procedures and methods, lowest absence rate, suggestions for reduction of operating costs and elimination of waste?

Keeping in mind that the chief ingredient for success is recognition of fellow workers, one might experiment with such awards in the hospital at little cost and with the possibility of rich rewards.



Acme Newspictures

Injured victims of Los Angeles explosion. See page 116 for disaster story.

ALTOONA HOSPITAL
ALTOONA, PA.

Train Wreck Points a Moral

ROBERT L. GILL
Superintendent

ABOUT 4 o'clock in the morning the telephone rings. Hospital calling. The night supervisor tells you a crack passenger train is wrecked 10 miles up the line. Many dead and injured. That is all the warning you will get that you have a major disaster on your hands.

All that happened during that long day cannot be described here. Seventy-six victims were brought to the hospital. Two were pronounced dead on arrival. Forty-three were admitted to the house and 31 were treated but did not remain over night.

First, you learn the ambulance is about to leave with blankets, morphine, dressings gathered from the wards. The intern is ready. The doctors are being called. We have two ambulances so you order an off-duty driver to be called and the second ambulance sent.

You cannot remember the six minute drive to the hospital but you have some plans when you arrive. The telephones are getting clogged and more speed is needed to notify essential personnel so you set up "chain phoning." Call one person and tell him to call two or three others designated by you and give orders for each. This helps the situation greatly.

The emergency department was to be the clearing station and looked to be in good shape, staffed with doctors and nurses and supplies coming from the central supply room. Much of the equipment and supplies assembled during the war for disaster purposes was still in storage at the hospital. From this supply, 38 army cots were set up and proved of good service. They are light in weight and can be used as stretchers and patients were moved on them to wards with a minimum of discomfort. Chief objections: they are hard to put together quickly and they tend to sag in the middle when carried.

Old patients in the house were sent home whenever possible so wreck patients could be given beds. Foldaway cots were used to augment regular beds. Chief objection: tiring to backs of doctors and nurses.

Relief trains were sent to the scene of the wreck as the volume of injured and the distance made this advisable. One lesson learned: use ambulance first to get first aid supplies, drugs and personnel quickly to the scene. Graduate nurses for relief trains were called for. Private duty nurses were used as well as a few of our staff. They were taken to the station in cars by two expectant fathers hanging around the lobby. What ideas you use!

When patients arrived the most seriously injured were dispatched to the wards and examined. Admission and office clerks searched clothes for identification, made out standard admission cards and placed valuables in the standard envelopes, listing valuables on the face of the envelope and following the usual routine except that patients' receipts for valuables and duplicates for our office file were eliminated as a time saver and because patients were not in condition to receive or care for receipts. It is important that somebody well known to all hands does this work so anyone not known by all can be stopped from searching clothes.

In the emergency department, a student nurse, later replaced by a stenographer, made out the usual cards. A record room medical stenographer can best understand and spell hastily given medical terms. A record librarian was used for two days in the x-ray department to augment that force for making out records and reports. She knew nomenclature and what was needed for a complete report.

Use experienced people on such work and green volunteers on less technical work. For instance, a reporter wanted the list of injured. He was allowed the use of a typewriter if he would make additional

(*Continued on Page* 64.)

MERCY HOSPITAL
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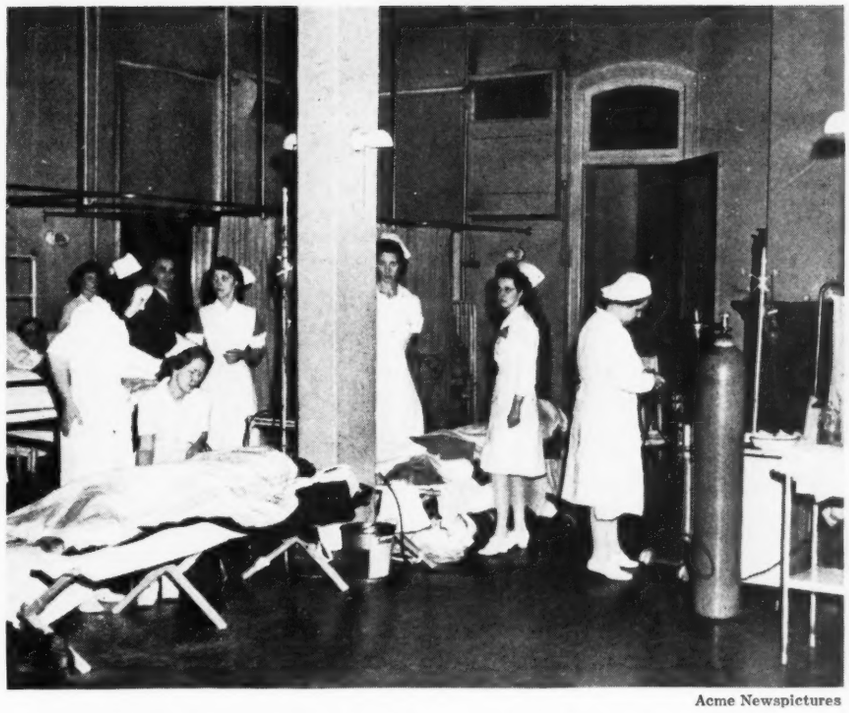


Acme Newspictures

The same scene was enacted in Altoona hospitals after the train wreck.

Be Prepared for Disaster

MOTHER M. OTILLIA
Superintendent

NOTWITHSTANDING the fact that every modern safety device is employed by the Pennsylvania Railroad for the protection of passengers and property, accidents happen. The wreck of the Red Arrow at Bennington Curve was one of those tragedies of the rails that shock the nation.

When our night supervisor, Jessie Dencler, received word about the disaster, she went into action immediately. Graduate nurses were sent to the scene at once; student nurses replaced the graduates on the floor.

Before the patients arrived, students who had already had dispensary training were called on duty immediately. The dispensary, the state clinic, a newly prepared physical therapy room and a former record room, all on the first floor, were prepared as emergency wards with cots set up to accommodate patients. Litters were waiting at the entrance to receive the victims.

Physicians were alerted. Some waited at the hospital while others reported to the railroad station where the injured and dead were being brought down the mountain on shuttle trains. Ambulances waited there to bring them to the hospital.

The morning care in the hospital went on as usual. Volunteer graduate nurses coming off night duty remained. Many patients who had special nurses for the morning released them to help the victims.

Graduate nurses as well as nurse's aides upon hearing of the disaster came from the outside and volunteered their services without being called. The orderly of the hospital also reported and offered his services. Graduate and student nurses assisted the doctors in the work.

As patients were brought in, immediate care was given them. They were examined for injuries and treated accordingly. Those who just needed first aid were washed and served hot coffee. Patients were made comfortable, and those who were able to go on continued their journey. Those who could not continue that day were given hospitalization. Patients who were seriously injured were given greater care.

All operations scheduled for the day were canceled. The x-ray examinations went through rapidly. While one patient was being examined, the dispensary doctors already had the next patients in line.

A nurse took the information from the patients as they waited their turn. Other nurses attended to their personal needs. The orderly was in charge of carting the patients. One technician took the x-ray pictures while another handled the darkroom procedure. This way there was no hold up. In less than ten minutes after the x-ray pictures were taken, a verbal report was given by the radiologist. The patients with fractures were turned over to the orthopedic surgeon for reduction and cast applications. Patients with more extensive injuries were admitted. There was no excitement and all patients were well taken care of.

In a disaster of this kind, we felt justified in canceling all scheduled x-ray work. Patients who were not hospitalized and had appointments, after hearing the news over the radio, were extremely considerate and called in to tell us that they would gladly step aside for the emergency victims. Their cooperation was greatly appreciated by the x-ray personnel.

Our personnel was experienced and efficient, our supplies were ample and our facilities, adequate. Despite the fact that it was a very busy day, the eagerness to help and the keen spirit of cooperation eased the unusual radiographic schedule.

As the number of patients increased, the Pennsylvania Railroad sent in cots, mattresses and blankets to make the patients as comfortable as possible.

The disaster committee and the Red Cross hurried to have ambulances available. Plasma, tetanus serum and gas gangrene antitoxin

(*Continued on Page* 64.)

ALTOONA HOSPITAL, ALTOONA, PA.

(*Continued From Page* 62.)

copies. Another reporter did the same. They are speedy and accurate and typed lists are ready for use in your departments, Red Cross information service and others. What might be a nuisance can be turned into an asset.

If supplies, equipment and personnel can stand the first rush, the critical time will soon be over. We fortunately had ample supply. From this experience, I should judge a few days' supply would carry over the first hurdle but this depends upon the size of the hospital in relation to the number of injured and does not take account of certain items like tetanus serum and oxygen tents. The type of accident would be a big factor.

Many persons will call, offering aid. Our nursing instructors under the director of nursing handled calls from nurses and nurse's aides. Remember it may be a long pull. Spacing of time to report for duty is important. You are going to need replacements. This holds true for all departments. The kitchen load will be oversized for the midnight meal. Will the laundry need to run a full twenty-four hours? The whole team is going to need substitutes that understand your equipment even if augmented by intelligent emergency help.

Remember, you have hosts of friends in the hospital field: administrators, supply firms, equipment salesmen. They will never let you down in a really tough spot. The Red Cross, state health departments, utility companies, army, navy, railroads, Salvation Army, Children's Aid, Family Society and such organizations, ministers and priests, air raid wardens, radio stations, newspapers, stores, every organization it seems, knows just what to do. It is amazing. Your hospital will not be standing alone by any means. You could not possibly think of it all or do a tenth of it alone.

In this accident, many of the victims were from distant points. We did not have the problem of crowds of people trying to identify or visit patients, which could be a real menace to the work in a disaster involving great numbers of local people. Police, firemen and air raid wardens might be needed and should be provided with instructions. The second and third days will bring problems.

Most of the newspapers and photographers cooperated well and deserve praise for fine coverage but there were exceptions. Before pictures are taken, we require permission in writing of the patient or close relative. We missed some and then the most innocent picture can be dressed up with a caption and description that will make your hair stand on end, and a long shot of a ward can be blown up and cut off until the picture has you looking down the patient's throat. I have not the solution for this problem but I learned a few new tricks as performed by experts.

Perhaps it takes a catastrophe to make one fully realize that preparation for disaster has an important place in hospital work. Because so many people remembered instructions and rehearsals from "blackout" days, there was smoother running in most efforts. It is my opinion that catastrophe drills should be staged like fire drills, not as often, but at least once a year. The whole community should participate. Every agency should have a part. The citizens could well stand some education as to what to do and where not to congregate.

National Hospital Day might be an appropriate day for such a drill. Many hospitals have no standard program. If National Hospital Day were set aside for catastrophe drills, the whole community could be brought naturally and wholeheartedly into participation. You take the weather as you find it for a good drill. Safety, accident prevention and other important educational features should be accented. Variation of theme would add interest—a theater fire for one year, a train wreck for another year, a factory explosion for the third year. Variation of time of day or night would add value to the drill if the time were kept secret.

This would give National Hospital Day a justly important position on the calendar, give a unity of endeavor throughout the country on this day in place of spotty and varied observance and would establish it as a day set aside all over the nation for planning the alleviation of suffering and pain. To what better use could we dedicate National Hospital Day?

MERCY HOSPITAL, ALTOONA, PA.

(*Continued From Page* 63.)

were also rushed to the hospital through the efforts of the Red Cross. Members of the Red Cross helped to relieve nurses and performed other tasks, such as making calls for the patients.

Three outside emergency telephone lines were opened shortly after the tragedy. Our switchboard was busy with inside calls and long distance incoming and outgoing calls. Wreck victims who were able to speak requested that their families be notified. Requests were promptly fulfilled.

Office clerks made rounds on the first floor to keep an accurate account of patients treated and a list of those who were hospitalized.

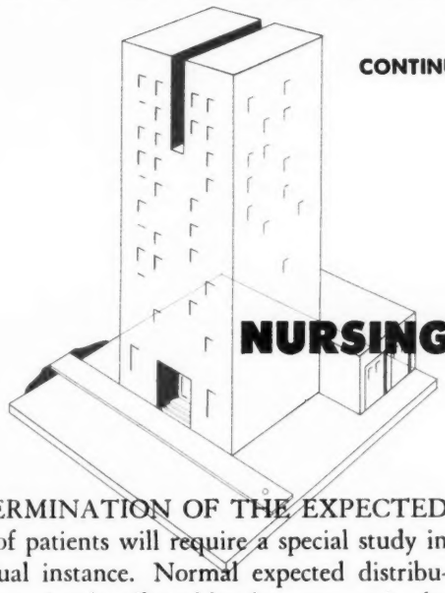
Toward evening several families came to seek their unfortunate members. Those who had relatives and friends at this hospital were comforted and directed to the bedside of the injured. Others were aided that they might find whomever they sought.

The doctors worked unceasingly all day at the hospital without reporting to their offices at all.

The first day, patients were placed wherever a bed was available. Later, those who were able to be moved were transferred to private rooms and were given special nurses at the request of the Pennsylvania Railroad authorities who were anxious to give the survivors the best of care and consideration.

THE FUNCTIONAL BASIS OF HOSPITAL PLANNING

CONTINUING A STUDY BY THE DIVISION OF HOSPITAL FACILITIES
UNITED STATES PUBLIC HEALTH SERVICE



NURSING FACILITIES

THE DETERMINATION OF THE EXPECTED distribution of patients will require a special study in each individual instance. Normal expected distribution might be seriously affected by the presence in the community of a specialty hospital, such as a maternity or children's hospital, or by the presence of recognized specialists on the staff of the proposed hospital or of other hospitals in the area.

Studies have indicated that normal distribution of patients in general hospitals might be expected to be: surgical, 45 to 50 per cent; medical, 20 to 23 per cent; obstetrical, 12 to 25 per cent; pediatric (other than newborn), 4 to 6 per cent; miscellaneous (including eye, ear, nose and throat), 9 to 15 per cent.

Inasmuch as bassinets for the newborn are not included in the hospital bed count, these do not appear in the percentages given. Space for bassinets, however, is included in the area allotments. Nursery facilities for newborn infants (including suspect cases) equivalent to approximately 140 per cent of the number of maternity beds will be required.

PATIENT AREAS

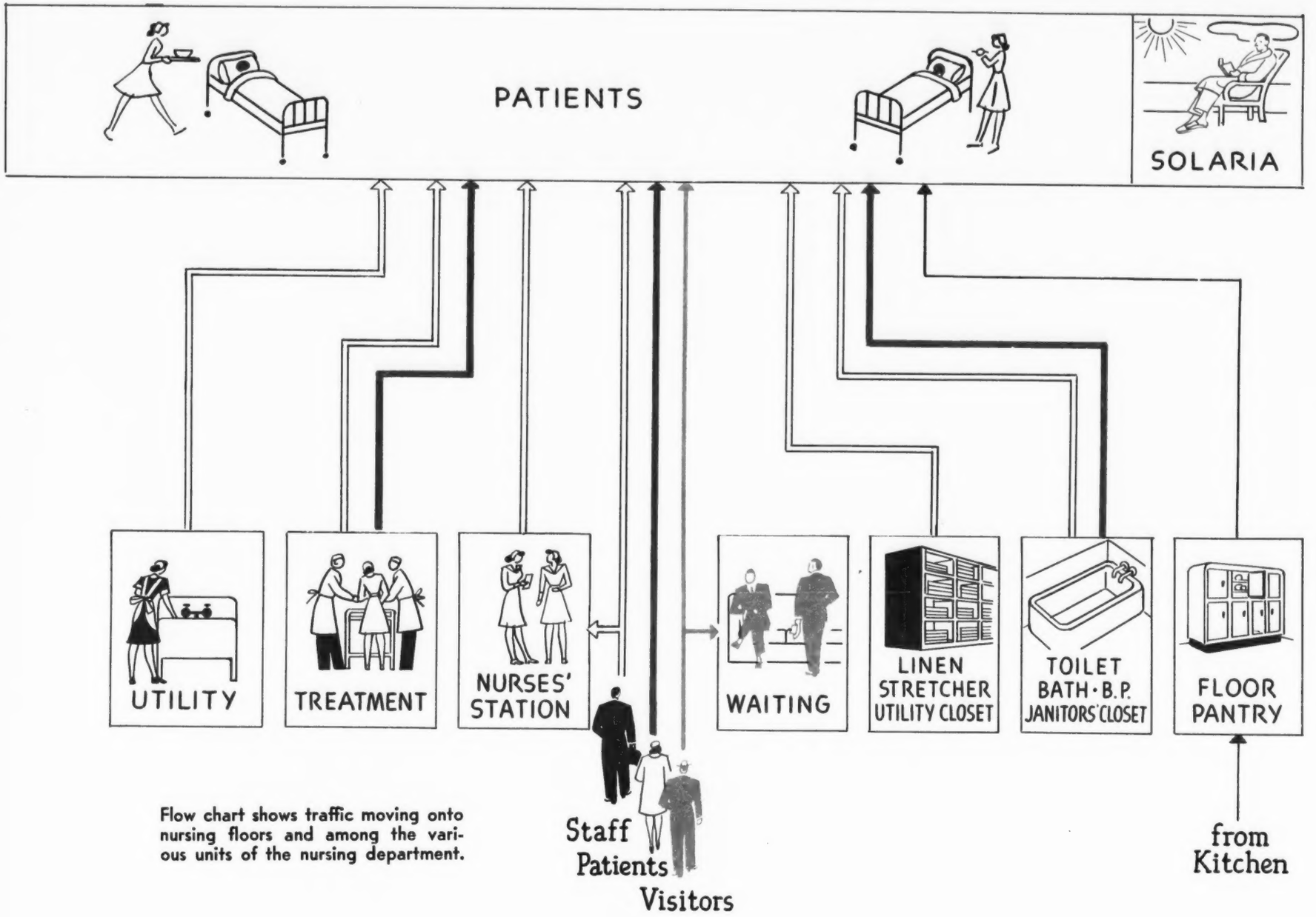
THE BED AREA ALLOTMENT in the tables on page 70 is intended to include the actual areas occupied by patients, whether in one, two or four bed rooms; toilets, baths and patients' room locker or closet space, when designed for the use of the room occupants; isolation rooms and their attendant individual utility areas, and any patients' rooms in the emergency area. The area allotted does not include circulation space.

The size of the nursing unit is limited by the number of patients that one nurse can care for at night and will normally consist of approximately 20 beds in single rooms; approximately 25 beds in a combination of one, two and four bed rooms, and approximately 30 beds in larger rooms. In small hospitals there should be one, two and four bed accommodations in each nursing unit in order to facilitate nursing service. This makes for the flexibility necessary to group patients on a basis of their medical or surgical conditions.

In allotting beds, unless there is a definite local reason for not doing so, it is well to adhere to the customary relationship of about one third of the beds in one bed rooms, one third in two bed rooms and one third in four bed rooms. A number of one bed rooms should be designed to permit accommodation of two beds in emergencies.

It is not considered feasible to have rooms of more than four beds in hospitals of from 50 to 200 beds, owing to the impracticability of proper segregation of age, sex, race and medical or surgical conditions in rooms of larger size.

Each nursing unit will contain patient accommodations (included in the "bed area") and those auxiliary nursing facilities required for proper operation. The auxiliary facilities required in each nursing unit



Flow chart shows traffic moving onto nursing floors and among the various units of the nursing department.

include the nurses' station, a solarium, two toilets, a bath, a bedpan room, a utility room, flower room, a linen closet and a supply closet. Isolation facilities should be furnished for each unit but should be arranged so as to be available for other patients when not needed for isolation.

In addition to the facilities needed for each nursing unit, certain other facilities will be required on each floor to serve the nursing units on that floor. These will include a visitors' room, a floor kitchen, a stretcher closet, attendants' toilet facilities, a janitor's closet and a treatment room. A special nurses' lounge may be considered if the type of patients expected will warrant extensive use of private duty nurses.

The areas required for these auxiliary facilities are not included in the "bed area" space allotment but are provided for separately. Those designated for the nursing units, however, must be so located within each nursing unit as to require maximum travel of not more than 80 feet to serve patients, and those designated for floors must be centrally located on each floor.

As far as practicable, patient accommodations in the various units should be oriented for sun, ventilation and quiet and the service facilities should be relegated to less desirable locations. In multistory buildings, it is of major importance that service facilities requiring plumbing or venting be so arranged that they are over each other on successive floors so that ducts, piping and stacks can be held to the minimum requirements.

Throughout the patient areas efficiency of operation, economy of space and the comfort of the patient are primary considerations. Besides the use of acoustical treatment in areas where noise is expected, structural methods should be used which tend to eliminate sound transmission through floors and walls.

Friction hinges or other devices should be used to prevent the slamming of doors.

Most room details show patients' room doors opening in toward the bed, giving increased privacy. In some institutions, however, such privacy may not be of major importance and some administrators have questioned whether this advantage is greater than that of having the door more out of the way of fixtures and traffic and of inducing better air circulation over the bed. This is accomplished by hanging the door from the opposite side.

Doors should be of the flush type and in patient areas must allow a full opening of at least 3 feet 10 inches in order that beds may pass through. Even with this width, doors should be hung on offset hinges or the hinge edge should be protected by a metal strip or otherwise.

Arm hooks, with hooks pointing downward, are used on patients' room doors. Vision panels are indicated in isolation and psychiatric rooms and in all double acting doors. The latter also need push and kick plates.

Even with the rapidly increasing use of artificial lighting and air conditioning, natural ventilation and lighting will be required for many years, for both psychological and financial reasons. While exact window area requirements will vary with climate, building and window design, average requirements will be 1 foot of window area to each 3 or 4 square feet of floor space. Space from the top of the window to the ceiling should not exceed 12 inches.

Sill height of 3 feet is recommended to permit an outside view from the patient's bed. The sill must be of substantial material inasmuch as it is common practice to place such items as flowers on it, and for this reason, as well as for protection from the elements, it should be able to withstand water, acids, stains and other damage.

Double hung sash permit only 50 per cent actual opening but are the least expensive. Triple hung sash give two thirds opening and are quite flexible; like the double sash, they are easily screened. Casement windows offer 100 per cent actual opening but make circulation difficult to control.

Horizontally pivoted sectioned sash, with upper sash swinging out, with inside screening, and the lower sash swinging in, with outside screening, apparently offer most promise for the development of a satisfactory hospital window. Usually a fixed center section is used with these. When partially opened this combination offers protection from drafts and the elements. The principal objection is the difficulty in controlling the upper section.

Larger glass sections provide for easier cleaning. The type of window installation will establish the best treatment for light control. Common roller shades are not particularly satisfactory. Continuous track curtains give horizontal but not vertical light control. Venetian blinds have the advantage of appearance and control but are difficult to use with a sash opening in.

Arranging the beds parallel to exterior walls and windows obviates glare or window light or the undesirability of the patients' facing an interior wall with no opportunity to look out of the window. Satin finish hardware to prevent glare is suggested.

Use of soiled linen chutes is, at present, a controversial subject. If used, the chute should be installed

in a convenient central location. It should be 24 inches in diameter and large enough to take a soiled linen bag, inasmuch as it is suggested that linen be counted on the floor and checked in the soiled linen room before the exchange linen is dispatched from the central linen room for replacement.

In larger hospitals, small floor laboratories are desirable on each floor for use by interns and residents.

Lighting in patients' rooms should be indirect. Ceiling lights should not be used. Reading lights, nurses' call, electric and radio receptacles for each bed and a night light, which is so located as not to be directly visible to the recumbent patient and which can be switched on from the doorway, should be provided. All switches should be of the silent mercury type.

ONE BED ROOM

One bed rooms should be furnished with a lavatory with knee or elbow controlled valves and gooseneck spout and may have a small toilet room with a silent water closet equipped with a device for emptying, flushing and cleaning the patient's individual bedpan. A few one bed rooms should be equipped with baths, as there will be a need for such so-called luxury suites. The furnishing of a private bath for each room, however, is regarded as unnecesary, although as many private toilets as funds and space will allow constitute a convenience for many patients and a saving in nursing time. In place of tubs, showers will be substituted in the maternity section. For safety, it is not considered advisable to place showers over tubs for use by patients.

It is advantageous to furnish at least one of the one bed rooms in each nursing unit with acoustical treatment for use as a quiet room, selecting a room located away from traffic and the noise of utility facilities. It is desirable to have a view window to a quiet room from the corridor, so that the nurse can observe the patient without entering the room. If this is installed, a draw curtain should be provided so that privacy can be obtained when required.

Whenever possible, one bed rooms should be of such size as to accommodate two beds in emergencies, thus furnishing flexibility in the capacity of the hospital. Because these rooms may be used for two beds in such emergencies, the wall outlet for nurses' call should be equipped for two signal cords and so located as to be accessible to both beds. Two clothes lockers or closets should be installed so they will be available for two patients. These lockers, with the lavatory, may be on the corridor wall or, if space permits, recessed between rooms.

The minimum floor area for any room should be not less than 125 square feet. The suggested minimum width for any room intended for patients' use is 11 feet 6 inches. Furnishing of dressers, as is usually desirable, will require an increase of this figure to at least 12 feet.

TWO BED ROOM

Two bed rooms should be provided with cubicle curtains but otherwise should be similar to the one bed rooms. A lavatory with knee or elbow operated valves and gooseneck spout should be provided near the door in each room; it should be so situated that a person using it will not be struck by the opening door if the door is hung on that side. The floor area should not be less than 160 square feet.

FOUR BED ROOM

In the small hospital, and in any general hospital, desirable flexibility is not possible if rooms exceed four bed capacity. Four bed rooms are similar to the two bed room discussed, including cubicle curtains and a lavatory. Floor area should not be less than 320 square feet.

CHILDREN'S UNIT

There will normally be no occasion for a separate pediatric unit in small hospitals, as these cases will be cared for in one or two bed rooms.

In large hospitals, where the patient load permits, rooms should be arranged especially for the care of children. This arrangement will be similar to that in one and two bed rooms except that it is desirable to have fixed partitions between the beds and curtain closure of the cubicles. Partitions should be 7 feet high with shatterproof glass above the height of mattress (36 inches). Cubicles are best planned to receive adult beds as these are used often. Hence, partitions should extend 7 feet from the wall; projecting curtain rods will then permit a 2 foot working space between the foot of the bed and the curtain.

Glazed (above mattress level) partitions between rooms and on the corridor side are advisable for improved nursing control. These, with cubicle partitions, require draw curtains. Appearance and sanitation are improved if recessed curtain lockers are built in. This recess may be a simple cove or may be provided with a door.

Individual toy storage space in each room is necessary. A junior size toilet, lavatory and elevated bathtub may be considered. A free standing tub, accessible from all sides, is desirable. Water controls should be located outside the reach of the child in the tub.

It is desirable that a play space be provided. A solarium with an adjacent sun deck is preferable for this purpose.

ISOLATION UNIT

STRICTLY SPEAKING, ANY PATIENT'S ROOM should be considered as an isolation unit. Many patients are admitted with specific complaints, in addition to which there is often, at least initially, an unrecognized communicable disease. For this reason proper aseptic technic cannot be overemphasized; it must never be relaxed, and every possible barrier must be placed to ensure against cross infections, with particular stress on the human element in routine procedures.

Therefore, one bed rooms designed for use by known infectious or communicable disease patients, or for patients under observation, will require separate utility room facilities. If these rooms are arranged in pairs, a single subutility room may be designed to be used for both rooms. These subutility rooms should be equipped with a sink with drainboard and a utensil sterilizer but they will require no other fixed equipment.

Each isolation room should have a lavatory with knee action control, a hook strip for gowns near the corridor door and an individual toilet with bedpan flushing attachment. These rooms are intended for use as ordinary rooms when not required for isolation. It is advisable to locate these rooms either at the end of a corridor or off a subcorridor. Placing of one bed rooms on the opposing side of the corridor will permit additional isolation beds if needed, all to be served by the subutility room. Special communicable disease hospitals are not included in these discussions.

PSYCHIATRIC ROOM

IN THE PAST, facilities in general hospitals for psychiatric patients have been most inadequate or entirely absent. However, the trend toward improved care of such patients makes it imperative for general hospitals to provide modern diagnostic and temporary observation facilities.

In every general hospital at least one room should be available for such patients. One of the isolation rooms may be designed for this purpose. The windows should be of the detention type with shatterproof glass and openings restricted to 5 inches in one direction. The door of this room should open out, be capable of being locked from the outside only and have no hardware on the inside. A covered view window constructed of heavy shatterproof glass is provided in the door.

For complete safety for the occasional violent patient, there should be an inner metal screen guard, either recessed to pull in front of the glass window, or portable and capable of being locked into the window recess. The room should have enclosed radiators, flush lighting fixtures with shatterproof glass, no exposed piping and no plumbing fixtures.

Electric switches should be located in the corridor outside of the room. There should be an amply protected night light. Heat should be thermostatically controlled from the corridor. Acoustical treatment for the room is recommended. A private toilet with tub on a pedestal for hydrotherapy is considered desirable. This room would be available for regular patients when not required for psychiatric patients.

A more comprehensive psychiatric program will require more extensive planning and design.

TREATMENT ROOM

TREATMENT ROOMS are necessary on each patient floor. They should be acoustically treated and equipped with instrument sterilizer, supply cupboard, bulletin board, instrument cabinet, nurses' call, clock, special lighting equipment, liquid soap dispenser and an instrument sink with gooseneck spout and knee or elbow control. Space is provided for an examination table and a waste container.

NURSES' STATION

A NURSES' STATION IS NECESSARY for each nursing unit and should be situated to save as many steps as possible for the nurses. It should be open to the corridor with, perhaps, counter or rail separation from the corridor. These stations should preferably be located where visitor entry by stairs and elevators can be controlled.

In large hospitals where there is more than one nursing unit to a floor, the nurses' station will be centrally located in the nursing unit and a floor supervisors' station will command the visitor entry. The nurses' station will have space provided for a chart desk and rack as well as for an extra desk for the use of nurses and interns in writing up charts. On private room floors where special duty nurses are employed, additional desk space may be required.

The station will be equipped with a nurses' call annunciator; a medicine cabinet with separate locked section for narcotics; other cabinet space; small instrument sterilizer; an acid resistant sink below the medicine cabinet, having a gooseneck spout for hot and cold water with knee or elbow control; clock; bulletin board; toilet; intercommunicating telephone. Acoustical treatment is necessary. In large hospitals

Areas in Sq. Ft.	50-Bed	100-Bed	150-Bed	200-Bed
ADMINISTRATION DEPARTMENT				
ADMINISTRATION				
Main lobby and waiting room	465	520	675	865
Retiring room	—	110	110	110
Public toilets	130 (2)	130 (2)	130 (2)	210 (2)
Public telephone(s)	10 (1)	20 (2)	20 (2)	20 (2)
Admitting office	115	175	175	175
Social service	—	180	200	285
Information and telephone	45	80	80	90
Administrator	180	240	240	285
Secretary	115	115	115	140
Business office(s)	285	450	625	805
Personnel toilets	90 (2)	130 (2)	175 (2)	215 (2)
Record room	180	240	400	510
Director of nursing	130	130	130	215
Assistant director of nursing	—	—	—	215
Staff lounge library and conference room	225	455	500	635
Total	**1,970**	**2,975**	**3,575**	**4,775**

Areas in Sq. Ft.	50-Bed	100-Bed	150-Bed	200-Bed
NURSING DEPARTMENT				
PATIENT AREAS	2 nursing units	4 nursing units	6 nursing units	8 nursing units
(Nursing units) a				
Bed area *(includes room clothes lockers and private room toilets and baths)*	5,955 (50)	11,915 (100)	17,870 (150)	23,830 (200)
Treatment rooms	—	380 (2)	570 (3)	760 (4)
Solariums	965 (2)	1,930 (4)	2,900 (6)	3,865 (8)
Visitors	130 (1)	260 (2)	390 (3)	520 (4)
Nurses' stations	365 (2)	730 (4)	1,095 (6)	1,460 (8)
Toilets, baths, bedpans	300 (4 T) (2 B) (4 BP)	600 (8 T) (4 B) (8 BP)	900 (12 T) (6 B) (12 BP)	1,200 (16 T) (8 B) (16 BP)
Utility rooms	380 (2)	760 (4)	1,140 (6)	1,520 (8)
Sub-utility rooms	120 (2)	240 (4)	360 (6)	480 (8)
Floor pantries *(central tray service, used)*	250 (2)	500 (4)	750 (6)	1,000 (8)
Closets *(stretcher, linen, storage, janitor)*	240	480	720	960
Flower rooms	100 (2)	200 (4)	300 (6)	400 (8)
Total	**8,805**	**17,995**	**26,995**	**35,995**

Each nursing unit to comprise approximately 25 patient beds, distributed about ⅓ private room beds, ⅓ semi-private room beds, and ⅓ ward beds.

that are provided with pneumatic tube systems, connection with the medical record room may be supplied. Also, in large hospitals, a dumbwaiter to the central supply room may also be desirable.

The nurses' call system installed consists of a signal cord for each bed connected with a dome light over the patient's door and an annunciator at the nurses' station. A dome light and buzzer should be located in the floor pantry and the utility room. In addition, a dome light is placed at corridor intersections. Reset of buttons should be only at the bedside.

Two way telephone connections or microphone and speaker, in lieu of the conventional nurses' call, have proved very satisfactory where they have been installed and are not excessively expensive.

CONSULTATION ROOM

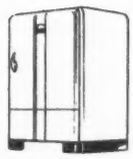
On each floor it has been found highly desirable to have a small room to serve as an office for the intern or resident physician, and to which attending staff members can retire for consultation and conferences with physicians, patients or patients' families. Such a room would require space for a desk, chairs, bookcase, locker, lavatory and house telephone.

UTILITY ROOM

The utility room should be centrally located in each nursing unit. This room requires ample cupboard and counter space, instrument and utensil sterilizers, utensil cabinet, clinical sink and double compartment laundry tray fitted with drainboard and gooseneck hot and cold water supply with elbow or knee control.

Space will be required for a crushed-ice box for nonbeverage ice, and a hot plate. It is preferable in planning the utility room to provide a separate area for the preparation of treatment trays and another for the cleaning of nursing supplies and equipment. Locked cabinet space is provided here for bichloride of mercury, phenol or other poisons not kept in the nurses' station.

It should be noted that the utility room suggested is not intended for bedpan cleansing or sterilization or for the sterilization of such supplies as are expected to be furnished by the central supply room. Acoustical treatment of this room is necesary. A 3 foot 10 inch door with vision panel is required.



FLOOR KITCHEN

If central tray service is used, the floor kitchens will have only minimal equipment and will not need to be equipped for setting up trays. They will, however, require space for a refrigerator of from 6 to 8 cubic foot capacity; an ice chest or ice cube machine; a gas or electric hot plate, and a toaster.

Cupboard space, a work counter and a sink with drainboard are necessary. The floor kitchens need acoustical treatment, bulletin board, clock, intercommunicating telephone and vision panel in door. They should be so located as to permit dumbwaiter service from the main kitchen.

If decentralized tray or bulk food service is contemplated, a larger area than that suggested in the accompanying area tables, and additional equipment, will be required as outlined under Dietary Department.

SOLARIUM

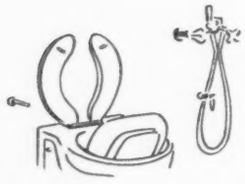
A solarium at the end of each patients' wing is highly desirable. It should be so arranged as to be available for utilization as bed space in emergencies. In order to accomplish this purpose a lavatory and nurses' call and convenience outlets should be installed. When the solarium is not being used for bed space it becomes a desirable therapeutic adjunct for the convalescent patient.

VISITORS' ROOM

A visitors' room for each floor is highly desirable. It should be located close to stairs and elevators and should be under control of the nurses' station. In larger hospitals in which the maternity service is heavy, it is considered good practice to provide a special waiting room for prospective fathers. Such rooms should be provided with a public telephone and acoustical treatment. Convenient toilets and lavatories are desirable.

FLOWER ROOM

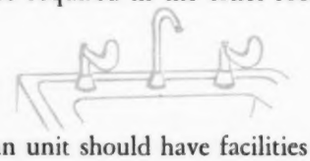
Space should be provided for a much needed workroom for the handling of flowers. This feature has been too often omitted in hospitals, which creates a definite problem for receiving, cutting, arranging of flowers, refilling vases, night or cleaning period storage of flowers and related functions often improperly handled in the utility room. The room should have a 36 inch high work counter with recessed sink, open shelves above and below for vase storage and space for waste receptacle. Larger hospitals may wish to provide refrigeration in this area.



TOILET, BEDPAN AND BATHROOM UNIT

EACH NURSING UNIT will be furnished with centrally located toilet, bedpan and bathroom unit.

The toilet rooms are arranged with doors opening out and may be provided with a nurses' call button. Two separate patients' toilets should be provided for each 25 bed nursing unit. Knee or elbow operated lavatories should be provided in toilet rooms, with mirror, glass shelf, paper towel and paper cup holders. A special dental lavatory for brushing of teeth is desirable. Acoustical treatment is advantageous in toilets. Inasmuch as separate bedpan units are to be supplied, facilities for disposal and bedpan washing should not be required in the toilet rooms.



The bedpan unit should have facilities for disposal, washing and direct sterilization of bedpans; a knee or elbow controlled clinical sink; bulletin board; recessed cabinet for specimen containers, and work counter. As individual bedpans and urinals are supplied, no rack is included in this room. A minimum of one bedpan unit should be provided for each nursing unit.

The bathroom should be provided with a tub but no shower because of danger to patients. Actually, few patients take tub or shower baths in general hospitals. Stall showers may be required in the maternity and isolation units, but never tub showers. A rod for drying rubber sheeting may be installed. One bath in addition to any private facilities should be provided for each nursing unit.

CLOSETS

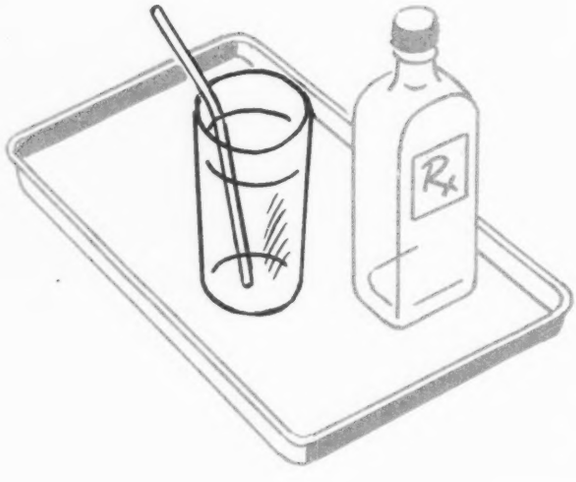
ONE LINEN AND ONE SUPPLY CLOSET will usually be required for each nursing unit. One stretcher closet and one janitor's closet on a floor will usually be sufficient.

The stretcher closet, which is more desirable than an alcove, should be arranged to accommodate at least one stretcher and one wheel chair. A cupboard with shelving may be installed above the level of the stretchers and wheel chairs for additional storage space.

A small linen closet will suffice in each nursing unit because a central linen room is proposed; hence, the individual linen closets need only be large enough to accommodate one day's supply of linen for the unit. Shelving should be provided in the linen and supply closets.

The janitor's closet should be a minimum of 5 feet 3 inches and equipped with a janitor's receptor, hangers for mops and brooms and shelving for cleaning materials.

All closets should be provided with lights, preferably of the automatic type. Adequate ventilation must be assured in all such areas.



There Should Be No Conflict

between volunteers and the hospital staff

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A RECENT inquiry among hospital administrators and department heads about friction between volunteers and the paid hospital workers discloses the gratifying fact that such friction is at a minimum. Of course, occasional personality clashes arise, but this is not peculiar to volunteer-staff relationships. Analyzing and understanding the causes for lack of friction today may help us meet possible future difficulties. Five principal reasons for the acceptance of volunteers by paid workers under present conditions emerge:

1. Most important is an appreciation by everyone that the volunteer is motivated by a desire to help mankind and is working without pay. It is generally understood that hospitals operate with deficits which must be made up by contributions from public spirited citizens. If these deficits can be partly met by the labor of volunteers rather than by actual monetary gifts, there should be no objection on the part of the paid worker. This labor is the volunteer's contribution to charity.

2. Volunteers have been present in hospitals for many decades and have come to be accepted as a matter of course. One of the earliest and most publicized volunteers was Florence Nightingale. The nursing profession has adopted her as a symbol of its spirit and as an example of all that is good in nursing.

Belongs to Volunteers, Too

It seems to me that volunteers should have as great a claim to Miss Nightingale as has the nursing profession. Her famous nursing expedition to the Crimea was organized on a volunteer basis. The present day volunteer can thank her for blazing the trail that has led to acceptance of volunteer service.

3. Paid personnel accepts the volunteer because she brings a new and refreshing attitude to what is often a monotonous job. The volunteer comes in from the outside world with a new point of view, with energy and with a desire to help. Such an approach must be appreciated by all staff members who have insight into the psychological problems of a hospital.

4. Friction between volunteers and staff is at a minimum when the hospital has a good personnel policy for the paid staff, with adequate pay, reasonable hours, paid vacations, sick leave and other employe benefits. Such a policy builds high morale; the staff worker feels that he is an important cog in a large machine giving service to the sick. In this environment, the volunteer becomes part of the team that is pulling toward the common objective of furnishing patients with the maximum of service and sympathetic understanding.

5. Volunteers rarely if ever displace paid workers. Their job is to supplement not to supplant the staff worker. There are several reasons for this. First, volunteers cannot be relied upon during the summer months, and the hospital cannot afford to have volunteers in positions which must be manned the year round.

Second, volunteer activities are primarily confined to those projects which make life more comfortable for patients. Volunteers facilitate smooth functioning of the clinic. They supply books and magazines to patients. They do all the hundred little things that make for luxury and greater happiness for patients. Most of these jobs would never be done by paid workers because the hospital could not afford the financial burden.

Third, the volunteer is seldom sufficiently well trained to take the place of a paid worker.

It seems reasonable to assume that the number of employes displaced by volunteers will always be small. If, however, the paid worker should be displaced, there would still seem to be little reason for resentment, because with more volunteer workers and a smaller paid staff the hospital could afford to pay adequate wages and because under present economic conditions only the most shiftless and inefficient fail to get jobs. Times will unquestionably change but for the present, at least, the hospital worker need have no fear of remaining long without work.

The point at which conflict is most likely to arise is in nursing. It is widely recognized that there is only one reasonable solution to today's nursing problem: more subsidiary nursing help. Because it is difficult to find properly qualified helpers or practical nurses today, the volunteer nurse's aide, who served so magnificently during the war, can fill the breach. I can see no conceivable reason for the nursing profession to resent her presence so long as the nurse understands her own position and the growth in importance of the nursing profession.

Duties Must Be Defined

To facilitate the smooth organizational functioning of nurse's aides a clear statement of their exact responsibilities should be prepared. A list of these responsibilities should be made available to all volunteer nurse's aides and all nurses. It might be wise to apprentice each aide to an individual nurse. The nurse may then direct the activities of the aide assigned to her and spend her own time in less menial tasks, leaving the bed making, flower arrangement and back rubbing to the nurse's aide under her direction.

Personality clashes will occur, of course, but these cannot be avoided under the best of circumstances. It will be up to the director of volunteers to fit the proper aides into the proper niches.

At Memorial Hospital in New York City we are now trying the

experiment of putting some of our former aides at the head nurses' desks as floor or ward clerks. If this works out satisfactorily, it should greatly relieve the head nurse of many of the irritating little interruptions that constantly upset the continuity of her work. To accomplish this, the aide should first be apprenticed to the head nurse on the floor or ward concerned.

To carry out a smoothly running program, free of friction and misunderstanding, these general rules for procedure must be followed:

1. Each volunteer should be carefully selected as to personality, training and aptitude and fitted into the position for which her abilities best qualify her.

2. The volunteer should be told by the director of volunteers to approach her work in a business-like fashion. A volunteer cannot be a lady bountiful; she must fit herself into the organization with a clear understanding that her status does not entitle her to any special consideration. She must be impressed with the necessity of taking the bad with the good.

3. The director should carefully brief all volunteers when they are first signed up in their exact duties, the limits of their duties and the person to whom they will be directly responsible. Printed or stencil duplicated instructions are desirable.

4. The director of volunteers must see that each worker is carefully supervised. Much of this supervision must be given by the department head or nurse for whom that volunteer is working. The director of volunteers must insist that this supervision is adequate.

5. The director must have the interest of the hospital administrator. She must keep him informed of her problems and urge on him the necessity of educating the hospital staff in the function and responsibilities of volunteers.

6. Appreciation and recognition of the work of the volunteers must be shown. There are various ways of doing this, but the best method is direct and personal thanks to them and encouragement from the hospital administration.

7. Most important of all, the volunteer must be kept busy. Let her run her legs off! She is giving her time, and if she does not utilize that time to the maximum of her capacity she will feel that she is wasting her efforts and that she is not needed by the hospital.

The administrator also has many responsibilities in the volunteer program. He must be sure that all the people in the employ of the hospital understand the charitable motivation of the institution and the status of volunteer help. He must build a high morale by a good personnel policy. It is especially important that he brief the nurses so that they understand their professional status.

Nurses must realize that their responsibilities are broadening daily, and the hospital must realize that this means increased salaries. Increased salaries mean fewer nurses, and fewer nurses mean more subsidiary nursing help. This must be understood completely and accepted.

For Handling Flasks Without Risk

EMMY LEHMANN, R.N.
Central Supply Room, Strong Memorial Hospital, Rochester, N .Y.

THE handling of hot solutions in the operating room is conducive to accident and may result in burns to the nurses or even the patient.

Flasks of saline solution are kept hot on an electric plate and, as necessary, some of this solution is added to a splash basin into which sponges are dipped. The sponges are used principally in laparotomies, gastrectomies and for irrigating abdominal cases. Deep areas are often wiped with wet sponges.

In the past the hot flasks have been handled with a towel and the caps or paper hoods have been removed for pouring, with care being taken to avoid contamination. The use of a towel to hold the hot flasks is dangerous inasmuch as the nurse may burn herself or the flask may slip and be broken on the floor with the possibility that the hot solution may splash and burn anyone in the vicinity.

To avoid these undesirable risks and to make the handling of the flasks comparatively simple an easily applied clamp which grasps the flask at the neck and body was devised at Strong Memorial Hospital, Rochester, N. Y. This clamp, which includes convenient handles made something on the order of ice tongs, permits the handling and pouring of these flasks without danger of their slipping. Heat conductivity of the handle is such that it is never hot to the touch. The incomplete bottom ring of the clamp encircles the flask well below the equator and thus prevents any downward movement of the flask. The clamp is provided with a locking device but is easily detached for the purpose of grasping another flask. The photographs show the essential features of the new clamp.

Contracts Can Be Liberalized

to include mental and tuberculosis cases

LOUIS H. PINK
President
Associated Hospital Service
New York City

A STRONG case can be made for payment for tuberculous and mental cases by the Blue Cross hospital plans, but it is not difficult to understand why these diseases have been generally excluded in the past. Blue Cross has no control of hospital service or what should be provided. If we were to try to influence hospital practice we should become extremely unpopular with our sponsors. We can provide for our members only those services which the hospitals in each community offer to the public.

Almost 30 per cent of all hospitals admit tuberculous patients. About 60 per cent of governmental hospitals admit them, but of the nonprofit or voluntary hospitals, which are the mainstay of Blue Cross, only 23 per cent accept cases of tuberculosis. The larger hospitals are more liberal than the smaller, probably because they are better able to provide separate facilities or are equipped for thoracic surgery.

Want to Keep Costs Low

In addition to the reluctance of the hospitals themselves to accept these patients, there has been a desire on the part of Blue Cross to keep the cost of broad service to the public low by eliminating those diseases which are adequately provided for by government. Those who suffer from tuberculosis and mental ills are usually not covered because they are, to a large extent, the wards of the state. Government usually provides care for these ills which afflict so many of our people, as it has for communicable diseases. But the quality of care has not matched the quantity.

Today's thought is centered upon early discovery and prompt treatment for both mental and tuberculosis cases. It is generally conceded that even if none of the marvelous new drugs, toward the development of which so many anxious eyes are directed, is able to attack and destroy the germs, tuberculosis can be wholly eliminated as a major scourge of mankind through prompt detection and adequate rest and care, as well as through decent housing and proper nutrition.

It is also beyond dispute that our rapidly growing army of mentally ill could be materially helped through preventive measures, prompt detection and effective clinical attention.

A recent study issued by the Committee to Study Hospital Service indicates that approximately one patient out of every 25 in general hospitals has at some time a serious nervous or mental disorder. About 3 per cent of patients brought to general hospitals for other illnesses are said to have active tuberculosis also, and they are undoubtedly more of a menace than are persons who are known to have the disease but who are properly segregated and cared for.

In the past it was thought dangerous to have mental and tuberculous patients in general hospitals, even though they were segregated in separate wards or pavilions. This belief is gradually being replaced by a more realistic attitude. A general hospital should, of course, not be a custodial institution, but it should be a center for the study and diagnosis of all types of diseases.

There is a tendency in several states to remove the means test in tuberculosis so that there will be no financial discouragement to prompt treatment. Governor Dewey recommended this in a recent message to the New York State legislature. This might seem an indication that Blue Cross protection is unnecessary. But the trend toward the treatment of tuberculosis and mental cases in general hospitals, and consequent Blue Cross protection, is constantly growing despite increasing government responsibility and more and better specialized hospitals for these diseases. Our efforts should be not to duplicate government or to compete with it but rather to supplement its effort.

The use of shock treatment for mental disease and surgical treatment, such as collapse therapy, for tuberculosis also brings these diseases closer to the purpose and scope of the general hospital, particularly the larger institutions. The use of general clinics and the general hospitals for preventive care for tuberculous patients will also be helpful in educating the profession generally so that it will be better qualified to cope with the disease.

Type of Coverage Varies

Coming more directly to what the Blue Cross movement can do to extend its aid, we find that considerable progress has already been made. Some 30 of the 85 plans provide coverage for mental and tuberculous patients to some degree. This varies greatly — from seven days to 150 days; some provide service for a limited number of days; some, a limited payment per day. Many provide care in member hospitals only. A few plans offer coverage for tuberculosis and do not provide for mental disease, and vice versa. But, generally speaking, those that provide for one provide for both, and usually the same benefits.

Albany. The Albany plan is one of the few that does not extend coverage for tuberculosis but does cover mental illness. For five years, from 1938 to 1943, only 232 cases were recorded at a cost to the plan of some $17,000. The average stay was thirteen days. Coverage is restricted to member hospitals; nothing is paid in mental institutions.

From an address to the New York Tuberculosis and Health Association of New York, 1946.

Colorado. Colorado provides ten days' protection for each disease, but only in general hospitals. In 1945 there were only 38 tuberculosis cases, costing approximately $1900, and 177 nervous cases, for which hospitals were paid about $6700. This does not include payment in nonmember hospitals.

This plan had more cases of alcoholism than of tuberculosis—217 against 38. It paid more than $7000 to the hospitals for alcoholism as against $1900 for tuberculosis. These figures are insignificant when compared with 31,834 hospital admissions during the year and $1,406,000 paid to hospitals.

Minnesota. Under its new comprehensive contract Minnesota now allows thirty days' full coverage for mental disease and tuberculosis, but only in Blue Cross member hospitals that accept such benefits. In 1945 there were 87 tuberculosis cases, which represent 1 per cent of all classifications, and for which the plan paid the hospitals approximately $5000. There were 242 mental cases, representing about 3 per cent of all cases during the year, which cost the plan $18,500. Minnesota provided hospital care for 77,385 subscribers and paid out $2,690,705 in claims. It is apparent that the cost of providing limited coverage for mental and tuberculosis cases was inconsiderable and was easily absorbed.

Rhode Island. The Rhode Island plan, which now covers 66 per cent of all the people in the state, offers the largest benefits for tuberculosis and mental cases, *i.e.* 150 days a year. City and state institutions and sanatoriums are included. In 1945 there were 89 tuberculosis cases, which cost the plan $7500, and 184 mental cases, which cost the plan $17,000. Rhode Island had approximately 325,000 members in 1945 and paid the hospitals $1,367,000 during the year. The director believes that there is no financial danger in this broad policy but recommends strongly that a cash limitation of $4, $5 or $6 a day be placed upon both tuberculosis and mental cases in other than member hospitals.

Kansas. The Kansas plan is also liberal. It provides ninety days for each of these illnesses, yet the utilization has been almost nil and the plan apparently absorbs the cost without difficulty and even pays in nonmember institutions. The trend in that part of the country is said to be definitely toward the treatment of tuberculosis and mental illness in general hospitals.

Wisconsin. Wisconsin has recently passed a law providing free care for tuberculous patients regardless of financial ability. Yet the tuberculosis cases have not as yet shown any drop. The plan provides sixty days for tuberculosis and mental illness. It is the opinion of the director that when an illness is provided for without cost by statute, it should not be covered by the plan. The director cautions that coverage of nervous disorders leads to considerable abuse and that strict supervision is necessary.

In 1945 there were 123 tuberculosis cases costing $15,800 and 383 mental cases costing $30,000. The number of tuberculosis cases amounted to only 0.3 per cent of the total number of cases and not quite 1 per cent of the total amount paid to hospitals. The mental and nervous cases represented 1 per cent of all cases hospitalized and 1.7 per cent of the payments to hospitals.

Michigan. The Michigan plan has always provided broad benefits for its members. For almost a year it has given thirty full days and ninety days at half rates for both tuberculosis and mental cases. During this period of almost eleven months it paid for 458 tuberculosis and 1211 nervous cases. This is not a large proportion when compared with the number of members who went to the hospital in a ten months' period in 1945—135,075 hospital admissions. Exact figures as to costs are not obtainable at this time. At the time of the liberalization of the contract, the charges to the public were increased. The director of the Michigan plan, however, says that the cost of these services is being absorbed without undue difficulty.

New York City. Associated Hospital Service of New York, which now has 2,300,000 subscribers, has always excluded tuberculosis and mental illness from its contract. We are more liberal than the strict contract provisions indicate. While we formally reject claims based on tuberculosis and mental illness, at the same time we routinely write the hospital that if there was any surgical procedure for the tuberculosis case or any shock therapy in the mental case, we will pay, just as we do for other illnesses.

Our actuary estimates that if we provided twenty-one full days for tuberculosis and mental and nervous disorders it would increase our payments to the hospitals about $700,000 a year. Approximately $200,000 of this would be for tuberculosis. Mr. Thompson's estimates, based upon the incidence of these illnesses in the general population in the city of New York, are obviously high because his basic assumptions include the indigent who are not provided for in any insurance plan, whether governmental or voluntary, and who are particularly subject to both of these illnesses.

The New York Blue Cross plan paid approximately $12,000,000 to hospitals in 1945. If our actuary's estimate is correct, the additional coverage would require an increase of about 5 per cent in our payments to hospitals. In recent years we have gradually increased benefits without correspondingly raising charges to subscribers. This has been done in the face of advancing costs and consequent larger payments to hospitals. Because of the additional compensation to hospitals we were unable further to increase benefits during 1946.

Contracts Not Liberal Enough

However, our liberal contract is not liberal enough. There are still restrictions which should be removed. The ultimate aim of the Blue Cross plans should be to pay the subscriber's hospital bill in semiprivate and ward accommodations. A few of the larger plans are attempting to achieve substantially that at the present time. In another year it may be possible again to increase benefits without increasing charges to the public.

In the case of our own plan, I think the first liberalization we are able to make should include the care of tuberculosis and mental cases for a limited number of days, not to exceed twenty-one, in general hospitals. This cannot be accomplished at the present time without an increase in rates. What the future will bring no one can answer now in view of the economic unrest and the rapidly changing price structure. In normal times emergent care of tuberculosis could probably be absorbed without increasing the rate structure.

Governor Dewey's program for increased state aid and the removal of the means test may make it unnecessary for us to cover tuberculous patients, but for the present at least and until the governor's program has developed into fact and we know how successful it is in providing the necessary care, Blue Cross should do its share in the program.

The care of mental cases is more expensive and more difficult. We must protect ourselves against the "rest cure." Experience everywhere has shown that any attempt to care for these cases will lead to difficulties unless carefully supervised.

Speaking more generally for the Blue Cross movement, the progress that is being made should be continued and if the financial experience continues to be satisfactory we should accelerate the pace. A definite period of full benefits limited from fourteen to twenty-one days would seem reasonable and would certainly provide that immediate relief for both tuberculous and mental patients which would encourage prompt treatment.

Blue Cross experience is worth while but has not yet been sufficiently studied and evaluated. But it is clear that it is both possible and practical for the Blue Cross plans to provide effectively for mental and tuberculosis cases for a limited period of days or without distinguishing them from other illnesses. Experience does seem to dictate that if service in other than general hospitals is provided a limited per diem rate should be set. It was never intended that the general hospital or Blue Cross plans should provide for chronic illness or custodial care; that is the obligation of the government.

Early Attention Required

A forward step on the part of Blue Cross would make it easier for the general hospitals to take early cases and give them the alert attention that is required. It would encourage hospitals to improve their equipment and to add qualified chest surgeons and psychiatrists to their staffs.

The general tendency of modern medicine is to discover illness before it has had a chance to spread and to give prompt and immediate preventive care. Certainly, ailments as important to the community as tuberculosis and mental disease cannot be overlooked either by the general hospitals or by the Blue Cross plans.

Population Trends in Mental Hospitals

RALPH C. TAYLOR
Pueblo, Colo.

POPULATIONS of America's psychiatric institutions are shifting rapidly into the higher age brackets and the trend is destined to continue, with greater burdens upon already overtaxed hospitals.

Five years ago only 17 per cent of admissions were of men and women beyond three score and ten years, but now the figure has jumped to 38 per cent. This is revealed in a study made by Dr. F. H. Zimmerman, superintendent of the Colorado State Hospital in Pueblo. In the past several months 38 per cent of all cases received at the institution have been at least 70 years of age.

Economic conditions brought about by the war have contributed to the trend, Dr. Zimmerman says. His investigation shows that many senile cases cared for in nursing homes have been shifted to the state hospital when the homes closed because of inability to meet the labor, food and rising cost conditions.

As the military forces and war industries pulled the younger generation away, individual homes were broken and aged persons suffering from mental illnesses were committed to the state hospital.

Another important factor that has contributed to senility has been the extension of the average life span. Just as cancer, heart diseases and hardening of the arteries are increasing as the number of elderly persons gains, so is senility.

"This has thrown a tremendous burden upon the state hospital," it is pointed out by Dr. Zimmerman, because "naturally these patients are much more difficult to care for than are those of a younger age group. Not only do they need psychiatric treatment, but also many of them require special medical, dental, nursing and dietetic attention. With a depleted staff of employes that still is not back to normal since the war ended, this situation has caused much distress at times.

"It is obvious that this trend is going to demand an increase in personnel, because all of this special attention cannot be given by even the normal prewar staff.

"It also has added to the housing problem. Normally we put 50 of these elderly persons into a ward. Now we are compelled to crowd 75 into each ward, or a 50 per cent increase.

"This overcrowding will continue until such time as our building program can be resumed. We have plans ready for several new dormitories, but we do not know when materials will be available."

Fewer Young People

There is a marked decline in the number of younger persons in the Colorado State Hospital. New treatments perfected in the last decade have done much to restore younger patients to mental health and get them out of the hospital. The war also siphoned off most of the younger age group that normally would go to a state hospital. Young men who break down mentally now are being cared for in governmental and veterans' hospitals.

A U. S. Public Health Service survey found that, until recently, the trend of requiring older persons to retire was damaging to their individualities. They are given the feeling that they are not wanted in the family and community and are in the way. The loneliness of seeing their friends passing away and the distaste for being dependent upon children also bring on mental disability, psychiatrists report.

General physical and mental decay is inevitable sooner or later, it is pointed out, and the problem of psychiatrists is to find remedies that will delay the decay, or at least to make the mind last as long as the body. The Colorado State Hospital maintains the spirit of research and treatment along that line.

When the Healthmobile Came Calling

Advance Publicity Ensured Its Welcome

TOM SPALDING
Public Relations Director
Shelby County Tuberculosis Society
Memphis, Tenn.

THE visit of the Brooklyn Tuberculosis and Health Association's $30,000 healthmobile to Memphis, Tenn., last spring proved such an invaluable aid in the accelerated case finding program of the Shelby County Tuberculosis Society that the experience gained may well prove of value to other organizations that are planning to add a visit of the vehicle to their activities.

Primarily, it is essential that recognition be given the fact that the unit is splendidly designed and constructed. Too high praise cannot be given those who conceived it. Yet it is necessary to realize fully that, regardless of its brilliancy of design, its intricate construction details, its unquestionable educational merit and its positive drawing power once it arrives on the scene, full advantage of these features cannot be obtained without proper and thorough advance publicity.

Wanted Every Ounce of Value

When it was first decided to bring the unit to Memphis, the elementary step toward getting every ounce of value from the visit was the selection of a healthmobile committee, members of which had the time, talent and tie-ups required in an all out publicity campaign. Once appointed, this group was promptly called together in an orientation meeting during which preliminary arrangements and assignments were discussed and made. Throughout the advance stage, this committee met regularly with designated society officers and staff members to check each phase and iron out the inevitable wrinkles that always arise in such efforts for complete coverage.

The healthmobile was not due to arrive in the city until April 20, but on March 4, when Edward J. Walton, advance agent of the Brooklyn association, arrived to clear details regarding the vehicle, the publicity program was already in progress with most of the fine points completed for its steady continuance.

This type of committee selection and publicity planning resulted in more than 10 columns of newspaper space; constant plugs, or spot announcements, over radio stations; an "on-the-spot" radio broadcast of the opening; a fifteen minute radio interview of the executive secretary; the usual police escorts and guards; thorough cooperation from the power company regarding the three necessary "hookups" as the vehicle changed locations; street banners; downtown department store window displays; x-ray companies' furnishing materials for window displays; endorsements by the mayor, chairman of county commissioners, sports personalities, civic leaders and organizations; participation in the opening by the health commissioner and social and civic leaders, and other "tell them about it" details which, together, assured the attendance of interested crowds.

All sections of newspapers were covered by specially designed articles and stunts. Society sections were reached by articles on the participation of Cotton Carnival ladies-in-waiting in the opening; sports attention was attracted by having members of the local baseball team given x-ray tests in the mobile unit, and by obtaining a statement from Bill Terry, former manager and first baseman of the New York Giants. News stories were, in the main, informative articles on the design and construction of the healthmobile, where it would be located and at what hours it could be visited, while a local columnist was induced to devote a column to the ideas, experiences and personalities of the Quarm brothers, who drive the machine for the Brooklyn organization.

Copy for radio spot announcements was prepared and furnished to the four local radio stations. The on-the-spot opening of the healthmobile was obtained by a little convincing conversation with one of the station announcers, and the interview with the executive secretary was arranged in a similar fashion with a young lady who conducts a daily program over another station.

Interest of school children was assured by contacts with school authorities, while church announcements, bulletin and vocal, were gained by the same procedure with the clergy. Cooperation of political, civic and social figures and active participation by business and civic organizations were also arranged through the same medium of personal contact.

The healthmobile goes on display in a street in Memphis, Tenn.

Gardens Grow Well at Triboro Hospital

RUTH M. NOBLE
Garden Club Director
Triboro Hospital, Jamaica, N. Y.

ONE Sunday morning a tall, thin man and a little girl walked slowly down the path of a rose garden. It was on these walks in the gardens and in the woods nearby that a love of growing things was first implanted in the child who was 10 years old and able to sense that the father she loved so dearly was very ill. They never walked together again, for before the last rose had fluttered from the garden that year he was dead—a victim of tuberculosis.

It was many years later that I, who was that little girl, was asked to go to a nearby hospital to replant some window boxes. As I mounted the steps and read "Triboro Hospital for Tuberculosis" over the doorway, my father seemed very near and I was glad that I had come.

I inquired for the medical superintendent. Friendly and gracious, he put me at ease at once and told me that the hospital housed some 600 patients, all of whom were adults, and that some window boxes which had been installed when the hospital was opened a few months previously already needed replanting.

A trip through the hospital revealed many of these boxes, all needing plants, and inquiry disclosed that this was a city hospital and there was no budget for such things. This was somewhat frightening, but also a challenge, and fortunately I had many contacts with garden club people so that plants were given and the work got under way.

During the weeks that followed, I came to know and like many of the patients and it became more and more apparent that there was a real interest in growing things which helped to pass the long days. One day when, trowel in hand, I stood talking to some of them, the question was first asked which has been asked so many times since: "How did you happen to come to Triboro?" I told them that because of garden club interests I had been asked to and one of the men spoke up, "It must be fun to belong to a garden club. Could we have one here?" I laughed and said, "Of course, why not? Anyone who is interested can meet me in the O.T. shop next Wednesday afternoon."

On the following Wednesday, seven men and two women were waiting for me and the Triboro Garden Club became a reality. A patient-president and patient-secretary were elected but no treasurer because there has never been any money to handle. It was decided to hold meetings twice a month at which a speaker would talk on some phase of gardening.

In those early days many mistakes were made which have since been corrected. It soon became apparent that the programs would present no problem. Speakers beyond the reach of the average garden club gladly gave their services. It was natural, perhaps, that I should have tried to get a large audience to welcome these important people but experience proved that this was unnecessary. Large meetings were noisy and a valuable lesson was learned, namely, that therapy is not accomplished by spectacular methods; it is an individual thing and its merit lies in a slow quiet working out of problems.

It took a little courage to announce that hereafter only patients who were truly interested in plants were welcome at garden club meetings but the results have proved that the policy was right and we have followed it.

Above: "Little Egypt" basks in tropical surroundings in his private pool in a window box. Left: The bridge was made by one of the patients.

A short time after the club started there began one of the most interesting tests of its worth. I was asked to speak to a patient, a Mr. R who had lost interest in everything. One morning I took some flowers in a basket and went in to introduce myself. To my surprise he said, "Stand still, right where you are. You make a mighty pretty picture there with the flowers." I laughed and said, "What, with my old gray hairs?" And thereupon was begun a friendship which was to influence many people.

Unhappy, discouraged, this man had been fast slipping into that state which all doctors dread. An invitation to join the garden club brought an amazing response. He loved flowers better than anything else, was, in fact, noted for his flower photographs, was an expert in photography. He also had beautiful slides at home. Would he show them to the garden club some day? He most certainly would.

New Interest—New Outlook

Mr. R was a bed patient but he was allowed in a wheel chair and could be taken to meetings. He became interested and his improvement was so marked that members of his family expressed their gratitude. After showing his pictures in the auditorium, he was asked to show them in his own ward, which he did on several occasions. A fellow patient interested in photography became an apt pupil and many long hours were passed talking over that fascinating hobby. The two became fast friends. Mr. R asked permission to write up meetings for the patients' paper, the *Triumph*, and some of these articles denoted great writing ability.

Mr. R could not get well. We knew that but we know, too, that the interest of the garden club changed his whole outlook and he thanked me many times for the happiness it had brought him. While he lived, he was president of the club.

At the end of that first winter it seemed logical to hold a few meetings on the roof. This was covered and was a pleasant place to meet. One day in August I planned a surprise. When the club members arrived they found no speaker but everything ready for a picnic. It was more than worth all the trouble involved to see the way that was enjoyed.

By this time we had established meeting days of second and fourth Wednesdays in the auditorium from 3 to 4. Supper is early at Triboro, as at all hospitals, and we never forget that our audience is composed of patients who must not be overtired.

Patients must of necessity be on the proper activity list to attend these meetings, so that garden club members really are divided into three classes. The first group includes those on strict bed rest to whom we give a garden magazine and sometimes just listen while they talk about their gardens at home. As they grow stronger they are given a plant to care for.

The second group comprises those able to attend our bimonthly meetings but not engage in any activity, while the third group, on a high activity list, takes care of the plants in the solariums and joins in other projects.

With no particular training for this work, I have learned several things by experience and one is that growing plants give more pleasure than do cut flowers. Flowers sent to a sick person are often not too fresh and the patients can only look forward to their dying. How much better to give a paper white narcissus bulb. It can be covered with a paper bag until the roots are established, and what a pleasure to watch those first green shoots and what great excitement when a blossom appears.

We have many window boxes at Triboro, all indoors, and we are continually experimenting with these and with flower pot gardening. Did you know green beans of acceptable size can be grown in a 6 inch pot? They can. We had them growing all through the wards last winter. Sweet potato makes a pretty plant, as does horseradish root. Morning glories grow well indoors and marigolds also.

One of the men patients, long since discharged, had a lot of fun with these. He grew them in a window box and took a keen delight when visitors came in asking them if he couldn't pick a flower or two for them. Their amazed stares were his reward. He would pick some flowers and present them with a great flourish. He wrote me after he left that he had had more pleasure out of those marigolds than from anything else that was done for him in the hospital.

Letters that come to me from patients after they have been out for a while are always most interesting. They look back on the garden club programs and speakers and appreciate them even more than when they were there. Some ask if they can come back for these meetings which is very flattering but, of course, could not be allowed for many reasons.

Last summer a roof project was started and both flowers and vegetables were grown. Here, again, we learned from experience what plants could withstand the heavy winds that sweep the roof. Not all could. Portulaca thrived, ivy privet hedge, small chrysanthemum plants, tomatoes, peppers and cabbages were grown.

Even with these boxes I learned that I must not impose my own ideas on the patients. Very carefully I drew up plans for these boxes so that they would look well. Low edging plants in front, graduating to tall ones in the rear, all to no purpose. The patients asked if they could plant them as they liked. And I realized what I should have known in the first place, that plants they had grown from seed in the wards were far better in their eyes than any I could bring in.

Like Unusual Plants

Herein lies the therapy and the most important thing to remember is that the garden club director is there to provide an inspirational activity for the patient, not a floral display to be shown to visitors. Patients also like unusual plants, something that visitors, doctors and nurses can ask them about. One patient has a philodendron growing in an electric light globe hung over her bed. It takes practically no care and she has had a great deal of pleasure from it.

The work has not been spectacular but has been built up slowly on small things, with the individual and his special needs always in mind and with the hope of encouraging a love for growing things. You would find no large displays if you came to Triboro. The club has no greenhouse, no gardener, no garden. It is only here and there that you see a propagating box, a patient reading a book on house plants, someone pasting dried flowers in a frame, arranging flowers for church services. This is the Triboro Garden Club.

PEOPLE IN PICTURES

Chicago Sun Photograph

Left: Dr. Julius Sendroy Jr., director of research at Mercy Hospital, Chicago; Carl A. Erikson, architect, and Dr. Andrew C. Ivy, vice president of the University of Illinois, look over the model of the proposed new Mercy Hospital.

Below: Margaret W. Johnston, Beloit Municipal Hospital, Beloit, Wis., retiring president of the Wisconsin Hospital Association, talks with John Hayes, New York.

Milwaukee Journal Photographs

Below: Nurse Gwendolyn O'Bannion of Henrotin Hospital, Chicago, points to the "emergency nickel" pasted to the telephone box in the nurses' home with the sign, "Use for Emergency Only," and the telephone numbers of fire and police departments. No nickels lost yet.

Acme Newspictures

Right: Discussing hospital problems at the two day institute sponsored by the Wisconsin Conference of Catholic Hospitals are: (from left) Sister Augusta, dean, Marquette University College of Nursing; Sister M. Bernadette, St. Anthony's Hospital, Milwaukee, president of the conference, and Rev. Edmund J. Goebel, Milwaukee.

SMALL HOSPITAL FORUM

Privacy Is What They Want

When They Are Admitting Patients

MOST small hospitals today are dissatisfied with their present physical facilities for handling admissions and would change these if they could to provide greater privacy for the admitting routine, a Small Hospital Forum on admissions procedures reveals.

Of 19 hospitals queried on this subject, 11 are carrying on admissions interviews over an open counter in the hospital lobby; six conduct the interviews in an office under varying conditions of privacy, and two routinely obtain the information needed for formal admission after the patient has been put to bed.

Seventeen of these hospitals are dissatisfied with the arrangements they have and would like to change them. In every instance where a reason for dissatisfaction is given, the need for greater privacy is stressed. Especially unsatisfactory, apparently, is the open counter method, which is often characterized as "very bad" or "most unsatisfactory." In a few instances, it is indicated, the interview is conducted in an office which may also have other occupants. This is also uniformly regarded as undesirable because of lack of privacy.

Of the two hospitals conducting interviews at the bedside, one indicates that the arrangement is satisfactory; this is a woman's hospital which rarely has an emergency admission. The other institution indicates that a private admissions office would be preferable if space were available.

The majority opinion on admitting space is probably summed up pretty well in this comment by an administrator: "I feel that the best setup for admittance provides a nicely appointed, not too small office, having entry to the business office and, in view of the frequent necessity for prompt services of a nurse, also having entry to the nursing office. This might not be desirable in a nursing school, but for the all-graduate staff I feel it is an asset."

All the hospitals, except those in which the interview already takes place at the bedside, state that in all nonemergency cases the admitting form must be completed before the patient is put to bed.

Naturally, the number of admitting clerks required varies directly with the number of admissions. While the ratio of daily admissions to admitting clerks on duty is by no means constant in this group of hospitals, the general rule seems to be that a single admissions clerk is all that is needed most of the time when admissions do not exceed 10 or 12 a day, but that two or more must be on duty, at least at certain hours of the day, when the rate ranges upward from this point. In most instances, admissions personnel on duty

Information Requested on Hospital Admission Forms

(The figure following each title is the number of forms on which it appeared among the 14 admission forms analyzed.)

Name—14
Address—14
Age—14
Nearest Relative—14
Religion—14
Occupation—13
Address of Nearest Relative—13
Doctor's Name—11
Employer—11
Marital Status—11
Birth Date—10
Previous Admission—9
Person Who Will Pay Bill—9
Birthplace—8
Employer's Address—7
Sex—7
Color—6
Mother's Maiden Name—6
Father's Name—6
Hospitalization Insurance—6
Mother's Birthplace—5
Father's Birthplace—5
Type of Case—5
Manner Received—5
Telephone—5
Diagnosis—4
Nationality—4
Payment Guarantee—3
Name at Time of Previous Admission—3
Hospitalization Insurance Policy Number—3
Address of Person Paying Bill—3
Blue Cross—3
Compensation—3
Recommended by (Other Than Doctor)—3
Employer of Person Paying Bill—2
Name of Hospitalization Insurance Co.—2
Lodge or Fraternal Order—2
How Long in United States—2
How Long in County—2
Deposit—2
Minister's Name—2
Husband's Birthplace—2
Husband's Name—2
Nearest Relative's Business Address—1
Father's Nationality—1
Mother's Name—1
Social Security Number—1
Relief Case—1
Nearest Relative's Occupation—1
Relation to Patient of Person Paying Bill—1
Head of Family—1
Employer of Family Head—1
Type of Hospitalization Insurance—1
Industrial Case—1
Valuables in Safekeeping—1
Approximate Bill—1
Husband's Birth Date—1
Brought In by—1
Operation Permitted—1
How Long in City—1
How Long in State—1
Patient's Maiden Name—1
Husband's Father's Name—1
Husband's Father's Address—1
Husband's Age—1
Husband's Address—1
Husband's Employer—1
Husband's Occupation—1

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SMALL HOSPITAL FORUM

Privacy Is What They Want

When They Are Admitting Patients

MOST small hospitals today are dissatisfied with their present physical facilities for handling admissions and would change these if they could to provide greater privacy for the admitting routine, a Small Hospital Forum on admissions procedures reveals.

Of 19 hospitals queried on this subject, 11 are carrying on admissions interviews over an open counter in the hospital lobby; six conduct the interviews in an office under varying conditions of privacy, and two routinely obtain the information needed for formal admission after the patient has been put to bed.

Seventeen of these hospitals are dissatisfied with the arrangements they have and would like to change them. In every instance where a reason for dissatisfaction is given, the need for greater privacy is stressed. Especially unsatisfactory, apparently, is the open counter method, which is often characterized as "very bad" or "most unsatisfactory." In a few instances, it is indicated, the interview is conducted in an office which may also have other occupants. This is also uniformly regarded as undesirable because of lack of privacy.

Of the two hospitals conducting interviews at the bedside, one indicates that the arrangement is satisfactory; this is a woman's hospital which rarely has an emergency admission. The other institution indicates that a private admissions office would be preferable if space were available.

The majority opinion on admitting space is probably summed up pretty well in this comment by an administrator: "I feel that the best setup for admittance provides a nicely appointed, not too small office, having entry to the business office and, in view of the frequent necessity for prompt services of a nurse, also having entry to the nursing office. This might not be desirable in a nursing school, but for the all-graduate staff I feel it is an asset."

All the hospitals, except those in which the interview already takes place at the bedside, state that in all nonemergency cases the admitting form must be completed before the patient is put to bed.

Naturally, the number of admitting clerks required varies directly with the number of admissions. While the ratio of daily admissions to admitting clerks on duty is by no means constant in this group of hospitals, the general rule seems to be that a single admissions clerk is all that is needed most of the time when admissions do not exceed 10 or 12 a day, but that two or more must be on duty, at least at certain hours of the day, when the rate ranges upward from this point. In most instances, admissions personnel on duty

Information Requested on Hospital Admission Forms

(The figure following each title is the number of forms on which it appeared among the 14 admission forms analyzed.)

Name—14
Address—14
Age—14
Nearest Relative—14
Religion—14
Occupation—13
Address of Nearest Relative—13
Doctor's Name—11
Employer—11
Marital Status—11
Birth Date—10
Previous Admission—9
Person Who Will Pay Bill—9
Birthplace—8
Employer's Address—7
Sex—7
Color—6
Mother's Maiden Name—6
Father's Name—6
Hospitalization Insurance—6
Mother's Birthplace—5
Father's Birthplace—5
Type of Case—5
Manner Received—5
Telephone—5
Diagnosis—4
Nationality—4
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How Long in United States—2
How Long in County—2
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Minister's Name—2
Husband's Birthplace—2
Husband's Name—2
Nearest Relative's Business Address—1
Father's Nationality—1
Mother's Name—1
Social Security Number—1
Relief Case—1
Nearest Relative's Occupation—1
Relation to Patient of Person Paying Bill—1
Head of Family—1
Employer of Family Head—1
Type of Hospitalization Insurance—1
Industrial Case—1
Valuables in Safekeeping—1
Approximate Bill—1
Husband's Birth Date—1
Brought In by—1
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How Long in State—1
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ABOUT PEOPLE

Administrators

Edgar Blake Jr., superintendent of Wesley Memorial Hospital, Chicago, for the last six years, died March 28 of a hearth ailment. He was 52 years old and had been unwell a great deal of the time following a severe illness two years ago. He had been a patient in the hospital for several weeks at the time of his death.

Mr. Blake was born in Connecticut, the son of a Methodist clergyman who later became a bishop. Following his graduation from Wesleyan University he entered the navy and served for two years during World War I. For the next ten years, he was director of a boys' home and school at Charvieux, France. In 1930 he returned to the United States and entered the field of hospital administration at the Methodist Hospital, Gary, Ind., where he was superintendent for ten years. He became active in hospital affairs right away, serving as president of the Indiana Hospital Association and delegate to the American Hospital Association while he was at Gary.

In 1941, Mr. Blake moved to Chicago to open the new Wesley Memorial Hospital on the Northwestern University medical campus. He was elected president of the American Protestant Hospital Association in 1942 and was active in the Illinois association and the Chicago Hospital Council.

Besides Mrs. Blake, Mr. Blake is survived by three sons and two daughters.

Louis Slatin, who was formerly personnel officer at Montefiore Hospital, New York City, has been named administrative assistant of Beth Israel Hospital, New York City.

W. Dayton Shields, past president of the Northwestern University Hospital Club, has been appointed superintendent of Asbury Memorial Hospital, Minneapolis. Mr. Shields is planning to complete the requirements for his master's degree begun while he was serving as administrative intern at Evanston Hospital, Evanston, Ill.

David V. Carter, who completed his academic work in hospital administration at Northwestern University in February, has assumed the duties of assistant superintendent of Fitkin Memorial Hospital, Neptune, N. J.

John W. Hollaway, director of the Louisiana Health and Hospital Survey at Baton Rouge, has accepted the position of administrator of the municipally operated Morrell Hospital, Lakeland, Fla. He succeeds **Mrs. Lillian Cook,** acting administrator.

George Rebush has resigned as superintendent of West Side Hospital and Dispensary, New York City, after nearly twenty years' service to the institution.

Dr. Robert H. Lowe has been appointed assistant medical director of Rochester General Hospital, Rochester, N. Y. Dr. Lowe has been associated with Strong Memorial Hospital as a postgraduate fellow in hospital administration. He was with the army medical corps for five and a half years where he attained the rank of lieutenant colonel.

Harold S. Fuller has been elected administrator of Monadnock Community Hospital at Peterborough, N. H.

C. K. Shiro, whose resignation as superintendent of Spartanburg General Hospital, Spartanburg, S. C., was reported last month, has accepted the post of administrator of City Hospital, Winston-Salem, N. C.

Dr. I. Oscar Weissman has been appointed to the position of assistant director of Jewish Hospital of Brooklyn, N. Y., to succeed **Dr. Benjamin W. Mandelstam.** During the war he served with the United States Public Health Service. Before assuming his new position he was district health officer with the New York City Department of Health.

Isidore Greenspan, executive director of the Brooklyn Hebrew Home and Hospital for the Aged, Brooklyn, N. Y., will celebrate his twenty-fifth anniversary with that institution on May 1. During his tenure, the capacity of the home has been increased from 109 to 711 beds. Plans are now under way for the construction of a new 400 bed structure and modernization of the existing properties.

Celeste K. Kemler, R.N., has been appointed administrator of Valley View Hospital, Ada, Okla. Miss Kemler is a native of Cedar Rapids, Iowa, and has held administrative posts at Eldora and Decorah, Iowa. She succeeds **John F. Barker** at Valley View Hospital.

F. Jane Graves, administrator of Alton Memorial Hospital, Alton, Ill., resigned on April 15. Miss Graves plans to take an extended vacation.

Robert S. Hudgens has been appointed administrator of the Lynchburg General Hospital, Lynchburg, Va., effective May 1, and has resigned as director of the Medical College of Virginia, Richmond, a position he has occupied for the last three years. According to Dr. W. T. Sanger, president of Virginia Medical College, who announced Mr. Hudgens' appointment, his new responsibilities will include, in addition to serving as hospital administrator, a study of community hospital needs looking toward the planning and construction of a new hospital. Mr. Hudgens will also supervise remodeling of the present hospital plant.

Prior to his appointment as director of the Medical College at Richmond, Mr. Hudgens was administrator of Emory University Hospital, Atlanta, Ga., which he also served as assistant superintendent for eight years before becoming administrator. He is a graduate of Emory University. Mr. Hudgens has been secretary for several years of the Southeastern Hospital Association, in which he has taken an active part ever since its organization.

Department Heads

Mrs. Mary D. Davis, R.N., has been named director of nursing at Hillsborough General Hospital, Grasmere, N. H., and head of the hospital's nursing school.

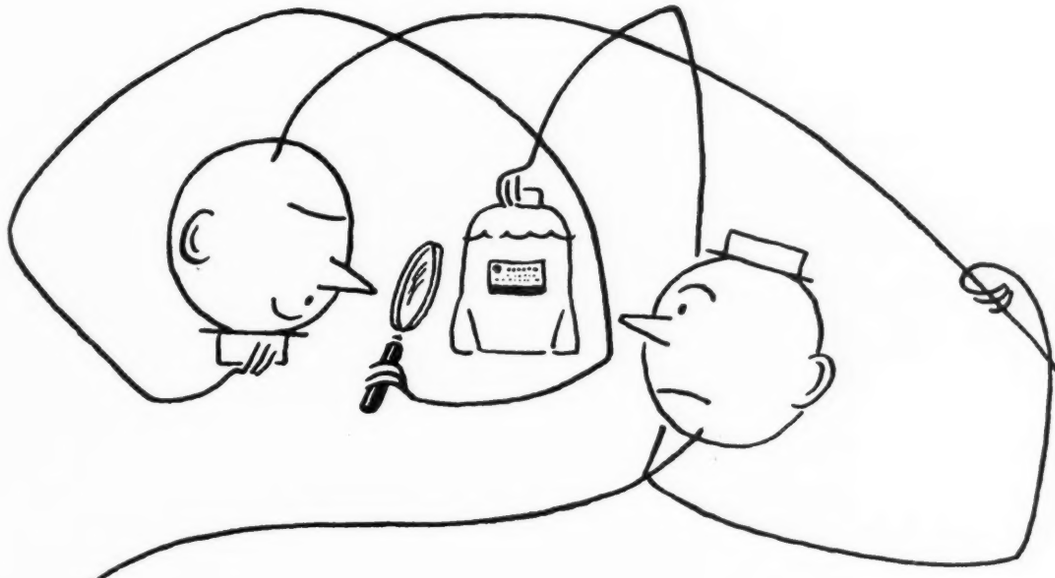
Ruth T. Mitchell, R.N., of Worcester, Mass., has succeeded **Mrs. Alma B. Van Pelt** as director of nurses at Elliot Community Hospital, Keene, N. H.

Harry O. Humbert recently assumed his duties as controller of Johns Hopkins Hospital, Baltimore. Previously, he was auditor and assistant treasurer of the Belvedere Hotel Corporation of Baltimore.

Otto Bodemer, former assistant administrator at Norwegian-American Hospital, Chicago, has accepted the position of purchasing agent at Illinois Masonic Hospital, Chicago.

Florence I. Rick has been appointed personnel director of Western Pennsylvania Hospital, Pittsburgh. A graduate

(*Continued on Page* 160.)



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The Public's Responses to Matters of Health

HARRY S. MUSTARD, M.D.
Director, School of Public Health
Columbia University Faculty of Medicine
New York City

FACTORS that influence interests and responses of the public in health matters, as in anything else, must rest, inevitably, upon certain fundamental attributes of human nature. These are not always nice or commendable from the standpoint of ethics, for many of them arise from selfishness, some from ignorance, others from prejudice, curiosity or the moth and flame complex. Occasionally, though, the public's interest and action in health matters transcend the nonadmirable, and then humanitarianism and self sacrifice reach their full flower. Nevertheless, one must remain realistic and recognize the factors that oftenest determine public reaction.

Impinge on Public Psychology

Even the most casual observation suggests that some health situations attract public attention more than do others. Those that get this attention appear to receive it because they impinge on public psychology in one of several ways. Further observation of this matter indicates that the following considerations are pertinent.

A health situation that has some specific association is more likely to attract public interest than is one that is vague and unanchored: A proposal for ensuring the health of mothers or infants or the aged gets more attention than does a diffuse appeal of good health for all.

A disease attracts more attention than health; people are more interested in avoiding the one than in attaining the other, for illness is a well remembered distress, while good health is, in most people, appreciated only in retrospect after it is lost. A disease that manifests itself dramatically gets more public attention than does one that has a tranquil, uncolored course.

Qualities that permit visualization in the public mind determine, partly, public interest in a health matter: Everyone has seen, and can repicture, a crippled child or the three dimensions of a tuberculosis sanatorium, but sewers are under the ground and early latent syphilis is sub rosa.

Problems and situations that involve a bit of physiological and anatomical mystery tend to attract interest, although manifestation of this interest may consist of nothing more than swapping misinformation at the bridge table; sex and its ramifications, new drugs, surgery and psychoanalysis all have a strong appeal.

Certain health matters interest one group of the public but not another: physical exercise appeals to adolescent boys; complexion-contributing or figure-enhancing restrictions, to young women, and old ones, too; infant care, to the enceinte; certain phases of endocrinology, to oldish men.

Character and Limitation of Responses. The responses of the public to education and propaganda may be as simple as 10 cents or as complicated as human nature, and some responses are much more difficult to obtain than others. In general, many people find that giving a dollar is expedient and cheaper than giving time to civic affairs; others will serve cheerfully on committees, or make a speech in the interest of having others accept restrictions or undertake regimes that they would not themselves observe.

Responses that entail continued individual and personal performances are the most difficult to get. Almost anyone is willing to make one effort but only a few have the fortitude to keep up health chores day in and day out, unless they are pleasant and lead pretty certainly and quickly to a singularly desirable and clearly recognizable goal, or their nonperformance is attended rather quickly by dramatic or disastrous results, or unless performance rapidly becomes established as a habit.

The Presentation of Health Matters to the Public. Over and above the characteristics of certain health problems and situations that of themselves attract public interest and therefore pave the way to public response, there is another factor which contributes to such a response. This is the manner of presentation of the matter to the public.

In any given situation the presentation must exploit whatever interest-arousing characteristics naturally exist; it must exploit, too, the vulnerability of the public to suggestion and exhortation; it must fit the suggestions and exhortations to the subject at issue and to the audience in view, and by sound of voice and size of print, by color of decorations and by length of sentence, by choice of words and pictures, by medium of conveyance and time of year and day, it must be directed toward those from whom favorable response is desired.

This problem of presentation is obviously a vastly complex one and, in relation to a disease or a health matter, encompasses a large part of the health education. One health situation may have many aspects suitable to picture and story and slogan, while another is lacking on all these counts. The mother with her infant in her arms may be glorified by throwing the camera on a professional model, or romanticized by the artist's brush; but it is difficult to do the same thing with an eight months' pregnancy.

Condensed from a paper presented at the fourteenth annual conference of the New York Tuberculosis and Health Association, 1946.

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One may profitably show x-ray pictures of the tuberculous chest to the public, but it would take a hardy and perhaps unwise soul to present in colors, as street car advertising, a true picture of a carcinomatous breast with secondary infection. Again, by news items, brochures, moving pictures and radio, it would be reasonably safe and somewhat interesting to describe the tolerable life of the average person in a tuberculosis sanatorium, but not existence in a psychopathic institution.

A nurse caring for the sick makes good copy, in picture, print and song, but the administrative mechanism behind that nurse is difficult to treat in even a fairly interesting and telling manner. Thus, publicity, propaganda and education find ready pegs for presentation in some instances, while in others successful presentation is almost impossible.

In connection with difficulties of presentation, thought might well be given to the question of whether or not a presentation that makes the public understand a health situation is a prime necessity. There are those who believe that this is of paramount importance, and perhaps it is. On the other hand, it is an ambition that may lead to much frittering away of time, to oversimplification and to dull stuff.

Documentation Not Essential

Understanding is, after all, a relative term, and even those who insist that public understanding in health matters is essential in obtaining public action do not really follow through. If they did, it would be necessary to provide for mothers a rather complete course in immunochemistry before they had their infants given a dose of toxoid; and it is to be doubted that children having their teeth filled are moved to do this because they understand the pathogenesis of caries. It is certainly arguable that honest and effect-producing presentation of health matters is possible in the absence of substantiating data and documentation.

One might even go farther and say that data, as such, do not form the foundation of effective presentation of health matters. Few lookers and listeners have the time, inclination or ability to absorb and digest quantitative data. They suffered mathematical wounds as children and most of them dodge figures.

On paper, in moving pictures or over the radio, the story of what happened in one family where there was heart disease will grip 96.3 persons for every 3.7 persons attracted by a table or bar diagram. It is particularly to be noted that the opportunities for personification, drama and romance that have come through radio and screen give a fresh and vital approach to a public that was unmoved by vital statistics.

Perhaps an illustration of many of the points here touched upon may be gained by referring to a situation which recently has been discussed a lot. This is the matter of the public's money response to voluntary health organizations.

The public, in 1945, gave evidence of its interest in poliomyelitis in terms of some $16,000,000 but charged itself with less than $50,000 because of its interest, or lack of interest, in heart disease. Surely, this was not because poliomyelitis, as a public health problem, is more serious than heart disease, for heart disease causes more than 400,000 deaths per year (1943) as against slightly more than 1000 from poliomyelitis.

Expressed in another way, it might be said that although for each death from poliomyelitis there are more than 300 from heart disease, for each dollar that the public gave for heart disease it gave more than 300 for poliomyelitis. Nor could this contrast in response to poliomyelitis and heart disease be related to numbers made sick, for in most years not more than 15,000 or 16,000 persons are reported as attacked by poliomyelitis, whereas reasonably reliable estimates indicate that the number of new cases in heart disease is vastly in excess of this.

Again, the length of illness in heart disease is greater than in poliomyelitis, and the various kinds of heart disease associated with rheumatic fever alone produce far more disability in children than is caused by crippling from poliomyelitis.

Is this greater interest in poliomyelitis due to the fact that children are principally affected? Here, perhaps, is a lead, but not necessarily the major lead, because, for every child reported ill at any given time from poliomyelitis, about 30 are believed to be incapacitated by heart disease. What, then, are the factors involved; why is it that the public is interested more in poliomyelitis?

One important element already referred to is that poliomyelitis is the disease of all diseases that the public regards as a threat to happy, healthy childhood. The second reason is that the after-effects of some cases of poliomyelitis dramatize themselves in a manner easily recognizable: crippling. A third element of importance is that, after a time, even the rather badly incapacitated poliomyelitis victim becomes ambulant or semiambulant. He thus gets out on the sidewalk or in the bus or subway and is seen by the man on the street.

Chivalrous Toward the Crippled

Now, if there is anything about which the hard boiled American public has retained a chivalry, it is in relation to the crippled person. Even a subway crowd in New York will make way for the man on crutches. In the same subway jam, the poor devil with heart disease, lacking any badge of his disability, is likely to have his short breath knocked clean out of his thorax. If this heart disease victim managed to get a subway seat, which is unlikely, and didn't give it to his obviously crippled but really far more robust brother standing nearby, then to his fellow passengers he would be a bum.

In relation to poliomyelitis, however, the matter goes far deeper than the fact that the public sympathizes with those who bear the scar of an adverse outcome from the disease. Over and above this, the public has a traditional horror of infantile paralysis. Perhaps more than in regard to any other present disease, parents fear that their child might be a victim to poliomyelitis.

But the case of rheumatic fever is in bed at home. A picture of him means little, his damaged heart is not visible, his shortness of breath is not three dimensioned.

Because the public thus fails to give consideration to the relative seriousness of diseases or to the comparative importance of one health proposal as against another, it has been suggested that all campaigns of public fund-raising activities for health services be pooled. Administratively, this is good logic, but not psychologic. There would be more danger of tearing down health undertakings that now get good public response than there would be likelihood of getting such a response from an appeal for good health for all.

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The Rochester Pean 6¼", photographed on the left, has been in continuous use for over one year. Points and serrations, box-lock and ratchets show no impairment in efficiency, and the mirror-finish is as bright as new. For comparison see the Pean on the right selected at random from our shelf stock.

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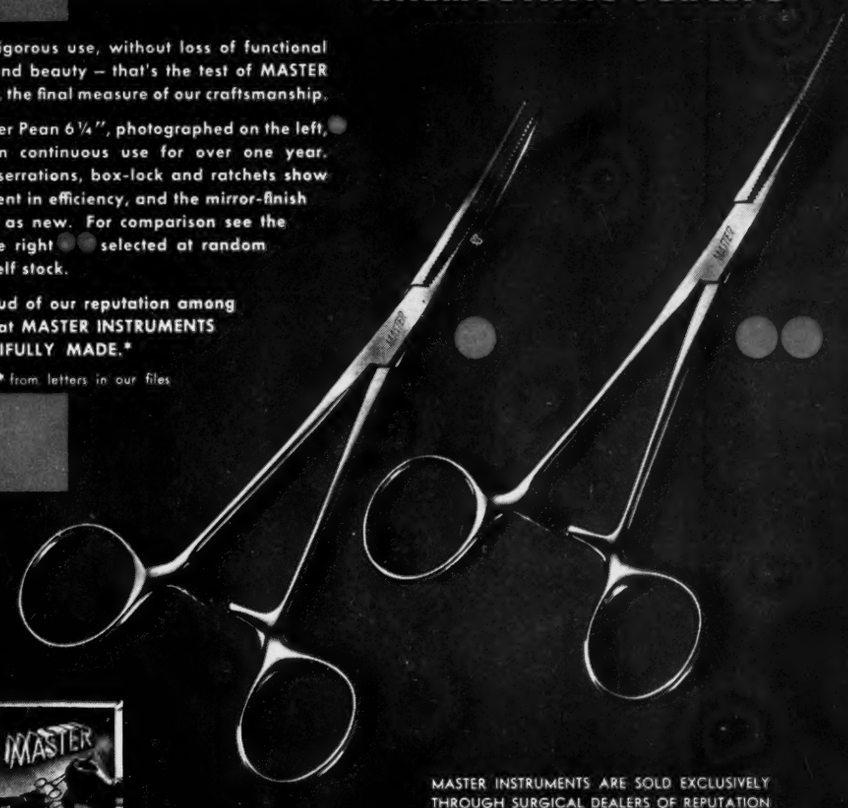
* from letters in our files



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MASTER
STAINLESS STEEL FORCEPS OF ULTIMATE PERFECTION

Monthly Report Is Good Business

EDWARD C. WATTS
Chief Pharmacist
St. Luke's Hospital
New York City

FROM time to time hospital pharmacists, writing in various journals, have indicated the necessity for providing the administrator with some regular record of the pharmacy's business activities. Of this necessity there can now be no doubt.

In the past few years, owing principally to the use of many new drugs and, incidentally, to increased activity in manufacturing processes in the pharmacy, the business of this department has increased tremendously. In fact, the budget of today's hospital pharmacy will be found to be among the largest of all of the departmental budgets.

Thus, in a 500 or 600 bed hospital, a yearly budget allowance of $100,000 or more may be needed to cover the cost of drugs, medicines and related supplies which can be expected to be used for the direct needs of the bed patients. An additional $25,000 to $50,000 may be required by the pharmacist to provide for the purchase of medicinal, chemical and pharmaceutical supplies used in other departments of the hospital.

Responsible for Large Sum

These sums of money, together with salary and operating costs, make up a total sum that warrants a well organized and accurate plan of accounting. Even in smaller hospitals the pharmacist is responsible for the proper utilization of a considerable amount of money and he should present to his administrator a careful and intelligent report of his expenditures and other business transactions.

To the best of my knowledge none of the pharmacists who have discussed the need for a record of business activities in this department has outlined in his paper recording procedures which would, in my estimation, provide the administrator with exact detailed knowledge of the daily, monthly and yearly business transactions of the pharmacy. Therefore, in this paper, the object will be to define a hospital pharmacy business report, to present a sample report and to outline the method of accumulating the necessary information for such a report.

The hospital pharmacy's business report should be a monthly one which summarizes the business of the pharmacy, indicates the value and, to a certain extent, the nature of the merchandise moved out of the pharmacy, shows where this material went and, finally, records the amount of cash collected and shows the value of the charges that have been transferred to the cashier's office.

It is unlikely that the pharmacist will have to develop many new procedures to prepare such a report. To use it as the basis for an annual report he will have to keep in mind the need for an inventory, a purchase record, a manufacturing record and any other miscellaneous records necessary to indicate the many transactions of his department.

In presenting here a copy of a monthly report from the pharmacy of St. Luke's Hospital, New York City, we realize that some of the basic procedures necessary to the making of such a report are already in use in many hospital pharmacies, but the form which has been developed in this instance, where the general situation seems as complex as possible, has not been seen in use elsewhere. Because it has been found satisfactory in so complex a situation it should be adaptable to other hospital pharmacies without difficulty. A brief description of St. Luke's Hospital will explain the variety of services rendered by the pharmacy and indicate some of the reasons for the form of the monthly report.

St. Luke's Hospital is a voluntary general hospital of 520 beds, with private, semiprivate and ward accommodations, the last being operated on an inclusive rate basis. Many of the ward patients are classified as "free," "city," "endowed bed" or "Associated Hospital Service" patients.

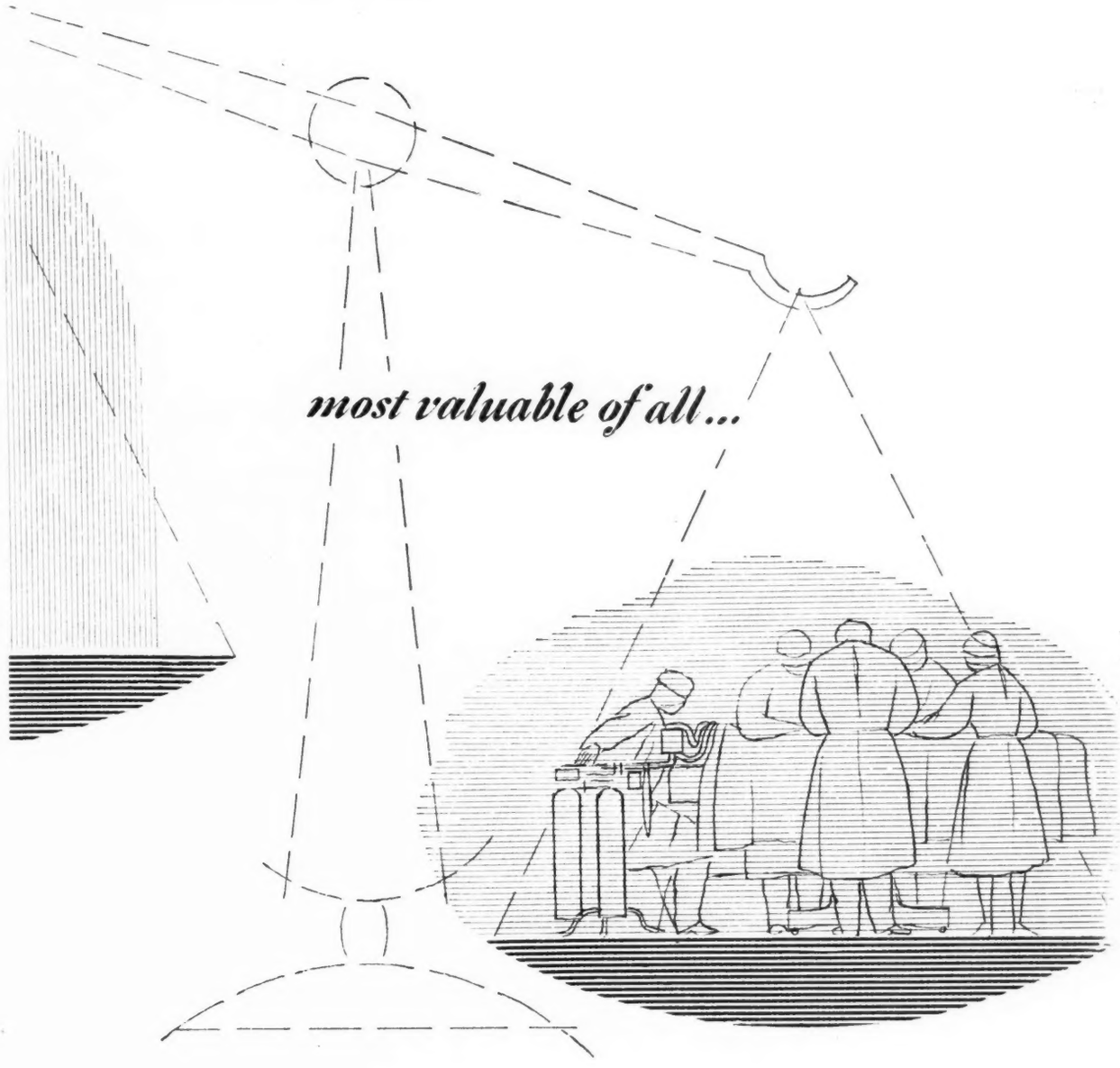
An active outpatient department, in which approximately 45 per cent of the patients seen are welfare clients, adds greatly to the work of the pharmacy. A convalescent hospital of 110 beds is an important adjunct to the main hospital and the greater part of the supplies for this unit is handled through various departments of the main hospital. An emergency medical and surgical service, which functions as a part of the admitting office; a nurses' infimary, and a personnel health service are other busy units which tend to multiply the activities of the pharmacy.

25 to 35 Drug Baskets Daily

In supplying the regular needs of these various units the pharmacy handles from 25 to 35 daily drug baskets with a large assortment of stock drugs. The wards and pavilions send down an average of 130 prescriptions each day and those from the outpatient department average 140 daily. This work, which is so briefly outlined, is handled by a staff of nine persons, five of whom are graduate and registered pharmacists.

To obtain the information necessary to compile our monthly report an analysis of the pharmacy's business disclosed that disposal of the stock could be accounted for by two types of transactions: (1) cash sales —to medical staff, employes and others; (2) charges and transfers—prescriptions charged to bed patients, merchandise charged to medical staff and employes and merchandise charged to other departments on various forms of requisitions.

The charge transactions were found to be in the majority and it is these and the forms on which the charges originate that account for the ma-



"... even recognizing other newer experimental anesthetics, we still might say that *ether is the most valuable of all* and that the discovery of its anesthetic effects was one of the most important milestones of medical progress."*

For over 88 years, Squibb has manufactured an ether renowned and accepted for its purity, uniformity and dependability.

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*Walton, R. P.: History of Anesthetic Drugs. J. South Carolina Med. Assoc. 40:69 (March) 1944.

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ST. LUKE'S HOSPITAL PHARMACY — Business Report for Month of October 1946

COST OF MEDICINES DISPENSED

UNIT	STOCK MEDICATIONS	SPECIAL MEDICATIONS	STOCK NARCOTICS	stock Barbiturates	Penicillin	TOTAL
Minturn I	20.39	64.33	6.85	4.15	211.20	
II	21.69	117.63	2.30	2.80	363.00	
III	23.00	243.55	6.15	2.00	258.00	
IV	12.96	157.40	1.20	2.15	154.80	
V	13.68	52.78	2.95		323.40	
Muhlenberg II	10.09	38.98	0.45		168.60	
III	18.01	17.63			84.00	
IV	35.55	35.20	0.25		22.20	
Norrie I	24.13	47.25	5.35	3.35	252.60	
II	17.49	272.57	6.50	2.00	303.60	
III	28.56	210.15	1.00	1.35	475.00	
IV	25.60	223.65	2.15	2.60	1243.80	
V	40.62	84.92	5.55	1.20	352.80	
Plant III (2/3)	12.59	329.88	1.94	1.07	34.20	
Sub totals for wards	304.36	1895.92	42.64	22.47	4247.20	
Total for wards						6512.59
Plant III (1/3)	6.30	163.94	0.97	0.54		
Scrymser I	20.68	324.23	5.15	3.90		
II	17.40	363.80	7.45	3.90		
III	17.13	299.08	4.25	1.20		
Sub totals for semi-pvt.	61.51	1252.05	17.82	9.54		
Total for semi-pvt.						1340.92
Plant V	11.38					
Plant IV	16.62	345.98	5.80	3.60		
Scrymser IV	19.47	422.80	4.85	3.20		
V	14.37	262.10	3.35	4.30		
VI	19.36	267.13	4.10	1.20		
VII	19.05	236.97	1.10	3.75		
Sub totals for pvt.	100.25	1534.98	19.20	16.05		
Total for pvt.						1670.48
Total Cost of All Bedside Medication		Forwarded — See Over.				9523.99

ST. LUKE'S HOSPITAL PHARMACY — Business Report for Month of October 1946

Brought Forward			9523.99
CHARGES TO SPECIAL SERVICE ACCOUNTS			
Admitt. Office	60.11	Brought forward	938.99
		Lyle Operating Rooms	394.67
Anesthesia	383.08	Out-Patient Clinics	207.21
Blood Bank	3.42	Out-Patient B Paid 1362	
		Out-Patient B Free 1118	
Convalescent Hospital	90.27	Out-Patient B Welf. 1148	
" " Rx (36)	60.20	Total No. 3628	@907.00
Cystoscopic	45.23	Paint Shop	
		Pathology	40.50
Dietary—Main	38.20	Physical Therapy	19.09
Dietary—Residence	0.65		
Dietary—Scrymser	16.55	Photography	8.11
Engineer			
		Radio Therapy	
Hospitality Shop	0.35	Religious work	5.20
Housekeeping	0.14		
		Solution Laboratory	4.43
Infirmary	97.52	School of Nursing	4.24
" Rx (130)	142.78	Sterile supplies	34.24
Laundry	0.49		
		X-Ray	138.12
Forwarded	938.99	Total—all charges to Special Service Accts.	2701.80
Total cost all drugs requisitioned			
Total cost all drugs used for month			12,225.79
INCOME STATEMENT			
Cash Sales		72.75	
Charge Sales		739.85	
Charges to patients		6411.40	
OPD Cash (1362 Rx)		889.00	
OPD Free (1118 Rx)		831.45	
OPD H.B. (1148 Rx)		883.35	
Special Service Accounts		2701.80	
Total			12,529.70
OPD Free Work		831.45	
Loss to N. Y. C. Welfare Department		267.99	
Loss to Hospital Free Work		691.03	
Total			1790.47
Net Income			10,739.23

Edward Watt
Chief Pharmacist

Left and above: Figs. 1 and 2: Obverse and reverse sides of the report showing costs and income.

jority of the entries on the monthly business report.

Our report (figs. 1 and 2) is printed on a standard 8½ by 11 inch sheet of paper, both sides of which are used. On the front and in the first vertical column are listed the costs of the stock medications supplied to the various nursing units during any given month. These cost figures are obtained by accumulating the daily drug requisitions during the month and totaling them according to units. In the second column, "Special Medications," are found the costs of all prescriptions filled for inpatients. These figures are obtained by pricing all inpatient prescriptions daily, accumulating these prices during the month, totaling them and calculating the cost. This involves a daily recapitulation of all prescription prices and the keeping of a day by day record of the total prescription charges.

The cost of the stock narcotics and barbiturates is obtained by accumulating the narcotic and barbiturate record sheets as they are returned and making a recapitulation of the cost figures that apply to these items. Similarly, the cost of the penicillin used is obtained by the accumulation of the penicillin requisitions (fig. 3) accepted during the month, figuring the cost daily and, finally, totaling the daily costs by units at the end of the month.

Three further comments in respect to this page of the report should be made here by way of explanation.

1. Our nursing unit, Plant 3, is regularly set up to render a combined type of service, two thirds of this unit's beds being ward accommodations and one third being semiprivate beds. Hence, the two entries for this unit.

2. It was mentioned previously that the wards of this hospital are operated on an inclusive rate basis. Semiprivate and private pavilions are not so operated; therefore, no penicillin is sent to semiprivate or private locations unless the drug is ordered on prescription for an individual patient with a charge being recorded on the patient's account.

Our penicillin requisition is designed for use only when penicillin is used for parenteral purposes in connection with the patients on the inclusive rate wards. Thus, our figures for the cost of penicillin represent only the cost of penicillin used parenterally on the wards, the cost of this drug when used on the semiprivate and private pavilions or when used for other than parenteral purposes on the wards being included in the prescription costs, "Special Medications."

3. The final total, "Total Cost of All Bedside Medication," may be compared with the amount of money budgeted for each month's purchases

PH 10

ST. LUKE'S HOSPITAL MORNINGSIDE HEIGHTS NEW YORK CITY

WARD STAMP: Med. 3 Pediatrics Med. A

PHARMACY WARD PATIENT PENICILLIN REQUISITION

DATE 10-23 19 46

PLEASE FURNISH SUFFICIENT PARENTERAL SODIUM PENICILLIN FOR USE DURING THE NEXT TWENTY-FOUR HOUR PERIOD ON THE FOLLOWING NAMED PATIENTS

PATIENT'S NAME	NO. OXFORD UNITS PER SINGLE DOSE	NO. OF DAILY DOSES	TOTAL NO. OF OXFORD UNITS
Paunetz, Robert	15,000	8	120
Beamer, Gary	20,000	8	160
Wingender, Donald	40,000	8	320
			600

NURSES WILL NOT WRITE BEYOND THIS LINE

DO NOT WRITE BELOW THIS LINE EXCEPT TO SIGN

TOTAL NUMBER 100,000 UNIT VIALS DISPENSED	6
COST	3.60

ORDER FILLED BY [signature] FOR PHARMACY

IN SIGNING THIS ORDER I HEREBY CERTIFY THAT ALL PATIENTS NAMED ARE WARD PATIENTS AND THAT NO NAMES OF SEMI-PRIVATE OR PRIVATE PATIENTS ARE INCLUDED.

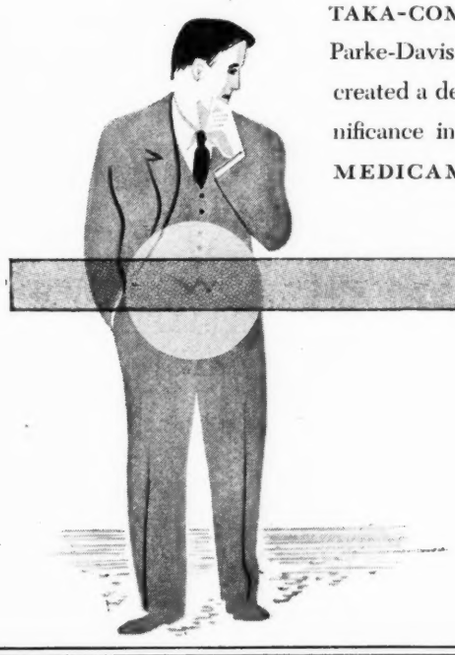
L. Crawford
NAME OF DEPARTMENT HEAD OR REPRESENTATIVE

Fig. 3: Penicillin requisition.

SYMBOLS OF SIGNIFICANCE

TAKA-COMBEX
Kapseals

Gastro Intestinal complaints are common concomitants of almost every disease process. G. I. dysfunction impairs digestion and imperils vitamin adequacy. **TAKA-COMBEX KAPSEALS** help meet these problems by joining the potent carbohydrate digestant action of Taka-Diastase with significant amounts of the well-known Combex combination of Thiamine (B_1), Riboflavin (B_2), Pyridoxine (B_6), Pantothenic Acid and Nicotinamide, together with other components of the vitamin B complex derived from liver; plus vitamin C.



TAKA-COMBEX KAPSEALS are one of a long line of Parke-Davis preparations whose service to the profession created a dependable symbol of significance in medical therapeutics—
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TAKA-COMBEX KAPSEALS are supplied in bottles of 100 and 1000.

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

MEDICAMENTA VERA · PD CO.

of drugs to ascertain whether the department is over or under its assigned budget allowance.

On the reverse side of the report the upper two thirds of the page is devoted to a summary of the charges placed against other departments of the hospital. These charges, which are for merchandise not included in the pharmacy's budget but which is nevertheless bought, stored and dispensed by the pharmacy as needed, either originate on requisition forms (stock drugs or general use items in the various departments) or represent the cost of prescriptions filled and dispensed through certain departments.

Summarizes Day's Business

In the case of the outpatient department a daily report summarizing the previous day's business comes to the chief pharmacist's desk each morning. This information is posted to the month's record of business. The prescriptions charged to the convalescent hospital and to the nurses' infirmary are comparatively few in number. A summation of the charges for them is made readily and directly from the prescription file at the end of each month.

After obtaining the total cost of all merchandise supplied to the "Special Service Accounts" this figure is added to that for "Total Cost of All Bedside Medication" to obtain the total cost of all drugs used during the month (this assumes that purchase orders for all drugs originate in the pharmacy).

The "Income Statement," which occupies the lower third of the second page of the business report, shows the pharmacist and the administrator the amount of cash which may be expected to be credited to the account of the pharmacy in return for the merchandise which has been dispensed in accordance with the explanations in the preceding part of the report.

"Cash and Charge Sales" are, for the most part, sales to employes and to members of the medical staff. There are included in the cash sales a few sales to "discharge patients." The figure shown as "Charges to Patients" is the total of all charges, minus proper credits, debited to all patients (ward, semiprivate and private) by the pharmacy. This figure is always reduced because of immediate credits, such as allowances and rate reductions, approved by the administrator. Such credits show on each monthly pharmacy report in the "Income Statement" as the third credit item, "Loss to Hospital Free Work."

The revenue from the outpatient prescriptions is summarized in the fourth, fifth and sixth debit items in the "Income Statement." No revenue is, of course, received from the prescriptions which are dispensed "Free." This item is offset by the first credit item and is included as a matter of record in accounting for the number of prescriptions dispensed.

Those prescriptions dispensed to welfare clients are shown in the item "O.P.D. H.R." (Home Relief). These are priced at regular clinic rates when filled and filed. When invoiced to the welfare department (New York City) they go at cost plus rates which are lower than are the regular clinic rates. A credit item showing the loss occurring on this transaction is therefore necessary.

Finally, the pharmacy needs to be credited with the value of the merchandise supplied to the "Special Service Accounts." Thus, the total seven debit items minus the total of three credit items represents the pharmacy's income for the month.

From a monthly report, prepared as outlined and pictured, the pharmacist may obtain the facts he needs if he expects to explain intelligently what is happening in his department, from month to month, insofar as the transfer of stock is concerned. Copies of the report, when supplied regularly to the administrator and to the accounting office, prove most helpful and come to be looked for and depended upon.

A year's accumulation of such monthly reports forms a firm basis for an annual report of the pharmacy's activities. The compilation of a regular monthly report does entail the daily expenditure of time and effort but it is an absolute necessity because the pharmacy has come to be responsible for one of the largest expenditures of the modern hospital.

NOTES AND ABSTRACTS

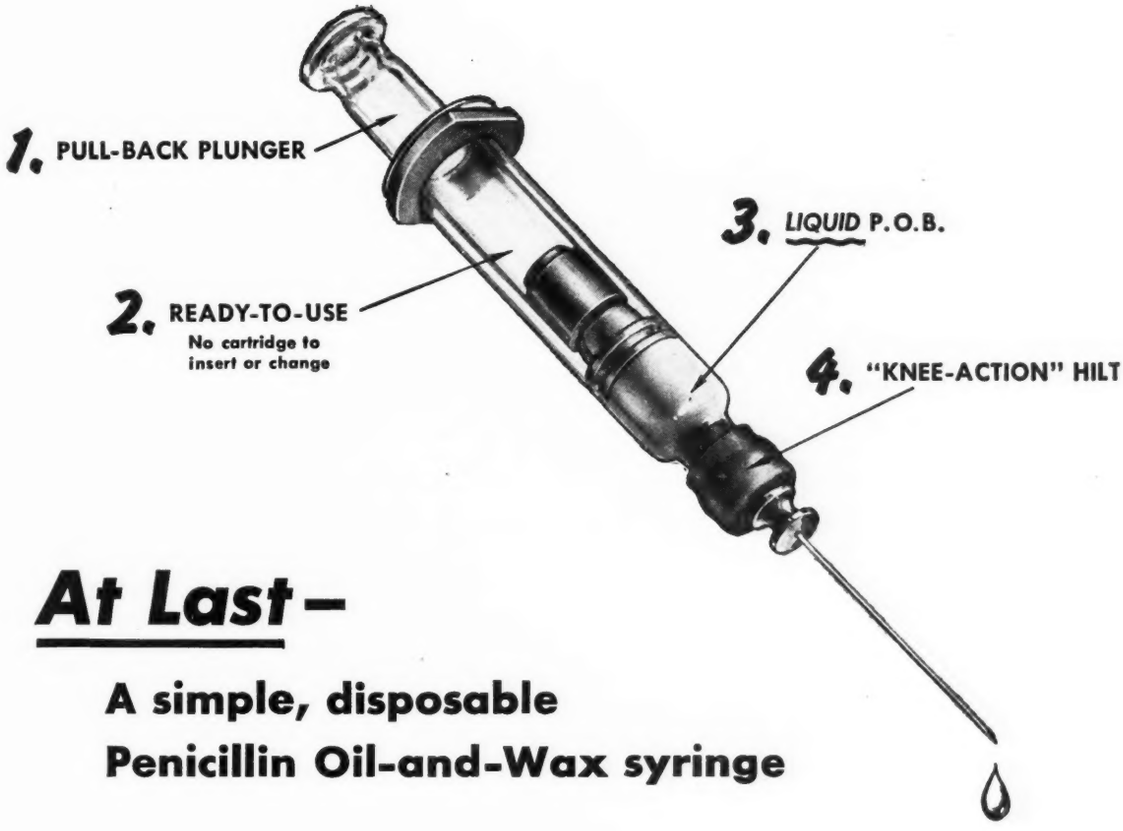
Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago 12

Introduction of Curare

FOR almost 100 years curare has been known for its remarkable power to paralyze striated muscle. Although, at the end of the last century, attempts had been made to introduce the drug in the treatment of tetanus, its use remained restricted to animal experiments in the laboratory. In 1932 Ranyard West obtained several highly purified fractions of curare from H. King of the National Research Institute in London. After extensive animal experimentation, West administered some of the preparations to patients with tetanus and with spastic disorders.

Clinical investigations were continued in this country with a curare preparation of standardized potency ("Intocostrin," Squibb). Mainly through the work of Bennett and McIntyre at Omaha, curare was introduced in 1940 as an adjuvant in the shock treatment with metrazol. The relaxing effect of curare on the skeletal muscle mitgated the severity of the metrazol convulsions without interfering with the effects of metrazol on the central nervous system. Thus, curare prevented fractures which occurred too frequently during metrazol convulsions.

In 1942 Griffith in Montreal and Cullen in Iowa administered curare during anesthesia in order to enhance muscular relaxation. Curare appeared to be of particular value in abdominal operations where the necessary complete relaxation could ordinarily be obtained only by very deep anesthesia. Suitable doses of the drug caused prompt and complete relaxation, and the anesthesia could be maintained on a lighter plane. Since



At Last—

A simple, disposable Penicillin Oil-and-Wax syringe

1. PULL-BACK PLUNGER . . . permits you to test for accidental puncture of a vein just as you always do. Simply pull back on the plunger. If no blood is aspirated—inject with confidence.

2. READY-TO-USE . . . . . Cutter's Penicillin Oil-and-Wax syringe is ready to use *"as is!"*

3. NO HEATING . . . . . This suspension at room temperature behaves like salad oil—rather than like butter. Easy to administer. (Cutter P.O.B. in vials *also* flows freely at room temperature!)

4. "KNEE-ACTION" HILT . . . acts as shock absorber. Needle is mounted in rubber, allowing "play" without danger of snapping needle. After using, toss the entire syringe away.

NO NEED TO ACCEPT A SUBSTITUTE . . . If these easy, ready-to-use Cutter syringes are not in stock, your pharmacist can get them . . . if *you* say the word.

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Berkeley, California

CUTTER
Fine Biologicals and Pharmaceutical Specialties

then curare has been employed in combination with every anesthetic agent. As an adjuvant in anesthesia curare enjoys today its widest application and greatest usefulness.

Preparations. Curare is available as a purified mixture of alkaloids prepared from crude curare ("Intocostrin," Squibb) and in the form of the crystalline alkaloid *d-tubocurarine hydrochloride* isolated in chemically pure form from various South American curares (Abbott, Burroughs Wellcome, Squibb). Intocostrin, which contains among other alkaloids d-tubocurarine, is standardized in biological units (1 cc. contains 20 units). From 20 to 100 units are injected intravenously in order to obtain relaxation or complete paralysis of the skeletal muscles. D-tubocurarine is available in a 0.3 per cent solution for injection; 3 to 15 mgm. of this alkaloid are as effective as 20 to 100 units of intocostrin.

Pharmacodynamic Effects. D-tubocurarine is only one of many alkaloids present in native curare. However, it is apparently capable of producing all effects for which curare has been noted. D-tubocurarine paralyzes the striated muscle selectivity. Its action begins with the weakening and paralysis of the short muscles of the head and neck. Blurred vision, diplopia and ptosis of the eyelids are the first signs. With larger doses the paralysis rapidly spreads to all muscles of the body and finally to the diaphragm. The cessation of respiration is due to the paralysis of the respiratory muscles; the respiratory center is not affected.

The effect of curare on the striated muscle is explained by a block in the transmission of the nerve impulse to the muscle cell. The conduction of impulses by the motor nerve remains unaltered. However, these impulses are no longer effective in stimulating the muscle to contract. The nature of this block is not well understood. Curare interferes neither with the liberation of acetylcholine at the nerve ending nor with the activity of cholinesterase. Its blocking action on the striated muscle is analogous to the blocking effect of atropine on autonomic organs innervated by parasympathetic nerves.

Curare has little or no effect on smooth muscle. Some clinical observations would indicate that it may relax the gastrointestinal tract in man. Also, small doses of curare are said to relieve menstrual pain by relaxing uterine spasm. Curare has no significant effects on the heart and the circulation. No effects on the central nervous system have been observed when curare is given in doses which paralyze the striated muscle completely and necessitate artificial respiration.

Curare produces no anesthesia or loss of consciousness. This has been demonstrated recently in a bold experiment by Smith and his associates in Salt Lake City. They injected a healthy volunteer with very large doses of d-tubocurarine intravenously and maintained the subject under artificial respiration in a state of complete muscular paralysis for several hours. During this time, the subject remained fully conscious and was able to hear and see, provided an attendant opened his eyelids for him.

On intradermal injection d-tubocurarine produces large wheals in a manner similar to histamine. It may also constrict the bronchial muscle

Rx DESITIN OINTMENT

The External Cod-Liver Oil Therapy

USED EFFECTIVELY IN THE TREATMENT OF
Wounds, Burns, Ulcers, especially of the Leg, Intertrigo, Eczema, Tropical Ulcer, also in the Care of Infants

Desitin Ointment contains Cod-Liver Oil, Zinc Oxide, Petrolatum, Lanum and Talcum. The Cod-Liver Oil, subjected to a special treatment which produces **stabilization** of the Vitamins A and D and of the unsaturated fatty acids, forms the active constituent of the Desitin Preparations. The first among cod-liver oil products to possess unlimited keeping qualities Desitin, in its various combinations, has rapidly gained prominence in all parts of the globe.

Desitin Ointment is absolutely non-irritant: it acts as an antiphlogistic, allays pain and itching; it stimulates granulation, favors epithelialisation and smooth cicatrisation. Under a Desitin dressing, necrotic tissue is quickly cast off; the dressing does not adhere to the wound and may therefore be changed without causing pain and without interfering with granulations already formed; it is not liquefied by the heat of the body nor in any way decomposed by wound secretions, urine, exudation or excrements.

DESITIN POWDER

Indications: Minor Burns, Exanthema, Dermatitis, Care of Infants, Care of the Feet, Massage and Sport purposes.

Desitin Powder is saturated with cod-liver oil and does not therefore deprive the skin of its natural fat as dusting powders commonly do. Desitin Powder contains Cod-Liver Oil (with the maximum amounts of Vitamins and unsaturated fatty acids) Zinc Oxide and Talcum.

Professional literature and samples for Physicians' trial will be gladly sent upon request.

Sole Manufacturer and Distributor in U. S. A.

DESITIN CHEMICAL COMPANY

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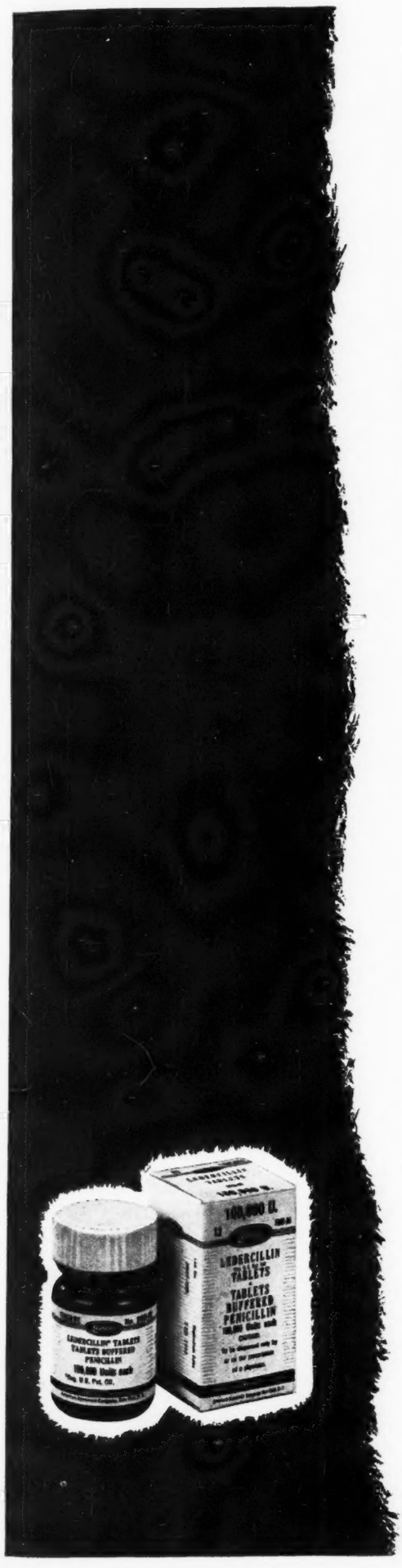

The "Danger List" Shrinks

WITH ADEQUATE ORAL DOSAGE OF

LEDERCILLIN*

PENICILLIN TABLETS

LEDERLE

It is never too early, whenever infection is *feared* or *suspected*, to administer ample dosage of oral penicillin. Think what this means to the overburdened nursing staff! It is the "danger list" patient who consumes the bulk of the nursing hours.

Adequate oral penicillin dosage will reduce the size of that portion of the danger list ill of susceptible infections . . . promptly!

Ledercillin Penicillin Tablets Lederle, *100,000 units, should be stocked by every hospital pharmacy!*

•

LEDERCILLIN Brand of Penicillin *Lederle*

Tablets: 50,000 Units—Bottles of 25 tablets.
100,000 Units—Bottles of 12 tablets.

Troches: 5,000 Units—Bottles of 25 troches.

Ointment: Tubes of one ounce.

Ophthalmic Ointment: Twelve ⅛ ounce tubes.

*Reg. U. S. Pat. Off.

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Lederle

LISTEN to the latest developments in research and clinical medicine discussed by eminent members of the medical profession in the Lederle radio series, "The Doctors Talk It Over," broadcast coast-to-coast every Monday evening over the American Broadcasting Company network and affiliated stations.

as shown in animals, by West. Occasionally bronchospasm has been noted by anesthesiologists.

Precautions in the Use of Curare. Curare is ineffective when given by mouth. It is always administered by intramuscular or intravenous injection. The margin between the dose affecting the small muscles of the eyeball and that causing paralysis of the diaphragm is small. Curare should never be administered unless facilities for expert and continued artificial respiration are provided. Obviously, it can be used with reasonable safety only by an experienced anesthesiologist. It abolishes all signs of muscle reflexes and respiratory activity on which the anesthesiologist usually relies in judging the depth of anesthesia.

The abolishment of laryngeal reflexes increases the danger of aspiration of foreign bodies into the trachea. Curare is more effective in ether anesthesia since ether itself possesses some curare-like effect on the skeletal muscles. About 50 per cent of the usual dose of curare which is used in conjunction with other anesthetics will produce complete muscular paralysis during ether anesthesia.

Contraindication. Curare is contraindicated in myasthenia gravis. Very small doses of curare aggravate the muscular weakness in such a remarkable way that curare has been used successfully as a diagnostic agent in this disease. Bennett and Cass have shown that 10 per cent of the dose which produces signs of paralysis in normal persons will produce typical effects in a person afflicted with myasthenia gravis.

Duration of Effect. The effect of a single intravenous dose of d-tubocurarine is short lasting. The drug is probably excreted rapidly by the kidney. Recovery from complete paralysis takes place within from ten to twenty minutes. Thus curare has to be given repeatedly at suitable intervals if longer lasting effects are desired. The injection of neostigmine (1 mgm.) hastens the recovery from the effects of curare.

Use of Curare in Spastic Disorders. The short duration of the action of curare has been discouraging in the treatment of spastic diseases. A new form of administering d-tubocurarine suspended in a mixture of peanut oil and wax by intramuscular injection increases the duration of its action and holds promise in the treatment of these and other neurologic disorders. The effects of curare in poliomyelitis have been disappointing. Curare should prove of value in controlling the convulsions in tetanus. However, only a few reports on its use in tetanus have thus far been reported.—KLAUS UNNA, M.D.

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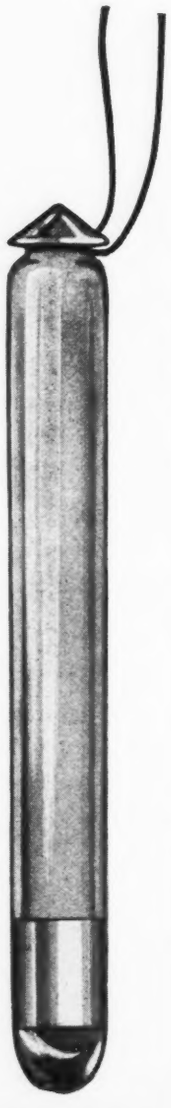

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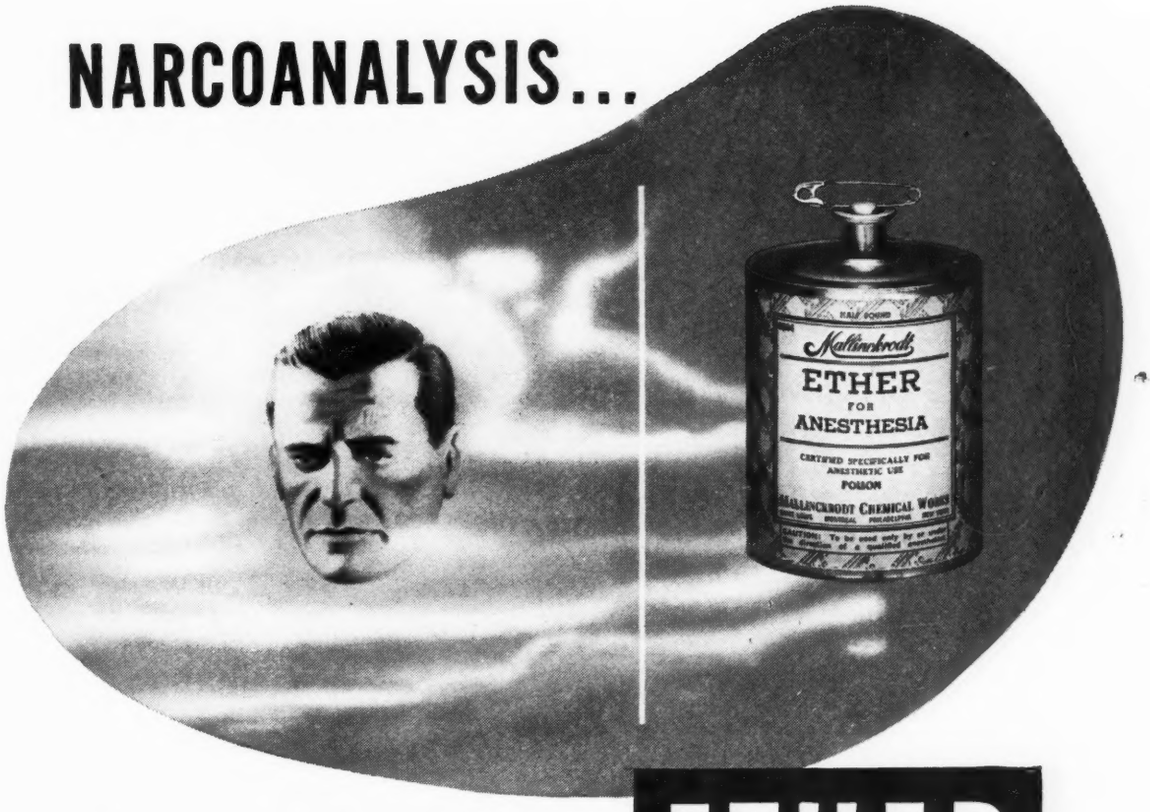
NARCOANALYSIS...



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Ether is generally safe. Levels of anesthesia can be maintained more easily and lowered more rapidly than with intravenous drugs. Necessary intense emotional responses are precipitated quickly. Patients retain useful memories of what has transpired because they remain conscious during and after interviews.

Unsurpassed purity, unquestioned stability and uniform efficiency are found in Ether for Anesthesia bearing the Mallinckrodt label.

[1] Brewster, H. H.: The Use of Ether in the Narcoanalysis of Patients with War Neuroses, New England J. Med., 235-357-9 (Sept. 12), 1946.

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FOOD SERVICE

CONDUCTED BY MARY P. HUDDLESON

The Dietitian as a Buyer

MARGARET COWDEN BERNARD

Chief, Dietetic Division
Veterans Administration Branch Office 13, Denver

EVERY dietitian is either an actual or a potential buyer, and the amount of money involved in her purchases amounts to a large part of the hospital budget. From 20 to 25 per cent of the hospital dollar is spent on food and, in addition, there are such items as equipment, cleaning supplies, linens and household furnishings in which the dietitian's decision is important. Her knowledge and ability as a buyer can pay real dividends even if only at the rate of a 0.5 per cent saving on the money expended. But to be a good buyer, either actively or in an advisory capacity, takes time, study and some experience.

Dietitian Could Complete Job

The dietitian, of course, has more knowledge of her food requirements than has anyone else. Unless a purchasing agent or business manager is trained in the food field, he will depend upon the dietitian for most of his information. She must initiate the requests for purchase and usually designates quality desired. In most instances she could complete the job by placing the orders and so facilitate the entire operation.

If the dietitian is the buyer, she is thus aware of costs and market trends and can make adjustments in her menus accordingly. Also, in periods of scarcity she can buy substitute items which are really substitutes nutritionally and not merely fillerins. Changes in menus must occasionally be made, particularly in fresh fruits and vegetables, and the dietitian can make the change and put through the order in much less time than it will take to notify the purchasing agent of the shortage in delivery, menu change and need for substitute items. Occasionally a purchasing agent may buy foods of inferior quality, a situation which the dietitian cannot control but for which, nevertheless, she must accept criticism. But if the dietitian is the buyer she is completely in control and fully responsible for the finished product. She is also in a position to be the best judge of what may be a real economy.

To buy items other than foods calls for experience and a knowledge of products other than in the food field. Equipment specifications, especially, must be extremely detailed and technical knowledge is required to write them properly. The dietitian in most cases will call on the engineer or other experts for the information she cannot supply. She, however, is in the best position to know what is needed and how to use the equipment and can, with assistance, buy such items satisfactorily. It is always wise to buy standard equipment because repair and replacements of parts are so much simpler and usually the performance of standard items can be better ascertained.

To be an efficient buyer does take time. Time must be set aside for interviewing sales people as well as for carrying on the routines of purchasing. Adequate office space must be provided for interviewing and for files. Accurate records must be kept as past experience is one of the best guides for future buying. Clerical assistance is necessary for typing orders, answering correspondence and filing.

First, the dietitian must know what to buy before she can place an intelligent order. This presupposes a detailed knowledge of the items desired. It is well to keep a good file of dealers' catalogs which are then available for instant reference. A visible card file showing items used routinely, with sizes, grade or quality, description or trade name, price and amounts, is also a time saver. The buyer must keep up with the markets, especially as to new items. Attendance at conventions where there are either food or equipment exhibits is an excellent way to keep informed.

Other means are: reading of advertisements in institutional magazines, visiting institutions and commercial installations for ideas, discussion with others in the field, attendance at lectures and demonstrations and last, but not least, seeking information from the salesmen.

Some buyers, especially those who are inexperienced, do not like to admit to a salesman that their knowledge of their needs is inadequate. Salesmen can be of inestimable aid by their knowledge of market trends, introduction of new items and technical information regarding equipment or other items.

Need Detailed Specifications

Detailed specifications can be made only after the buyer knows her needs and such specifications are necessary for efficient buying. These should include the quality, size, other description and quantity. The supplier can serve the buyer to the best of his ability only if he knows exactly what is desired.

In deciding as to the quality of goods to be purchased, the type of institution and the amount of money must always be considered. The administration should decide what level of food service is to be maintained and arrange for the proper amount of money to be set aside for that purpose. It should not be the responsibility of the dietitian to set these standards, although she may give valuable aid in determining what is possible from both an organizational and financial angle. It is economically unsound to buy the finest quality in all items even though finances are

unlimited—and few hospitals are in this class. Use of the item must be considered, as well as the budget, in deciding on the quality.

The buyer of food should know the grades available and the local suppliers' corresponding brand names. She should also know varieties and their particular characteristics, their use and the seasons at which they are available, for example, Jonathan, Delicious or Greening apples; Navel, Valencia or Pineapple oranges; Early June, Alaska or Telephone peas. She must know the sizes, weights or numbers in a package or unit as well as the special packs available, for example, spears, slices, whole or broken, dessert cuts or crushed pineapple, each of which is packed for a particular use. In general, institutional sized packages are more economical in both money and labor but there are occasions when smaller units are desirable for therapeutic diets or special orders.

Mistakes Are Costly

The description should include factors other than quality, size or trade name that will help to identify the item desired, such as type of material, gauge of metal and type of electric current necessary. For equipment this is vitally important. If a dishwasher has an A.C. motor and only D.C. current is available, expensive delays ensue before it can be used, inasmuch as a transformer must be installed or the motor must be changed. A mistake of only an inch in measurement may mean that a sink ordered for a particular space cannot be installed.

The problem of deciding on the quantity to buy perplexes all buyers to some extent. However, certain limitations must be considered; among the important ones are storage space and storage facilities.

A word might be added here regarding the importance of storage space for frozen foods. Now that so many of these items are available, holding facilities should be provided so that frozen foods can be used.

The size of the institution also limits the quantity of purchase. It is not feasible to buy potatoes by the car lot unless the daily consumption of potatoes is large enough to warrant such a purchase. Even if the consumption is large, unless proper storage is available car lot purchases are not a profitable way to buy.

The amount of money available also limits purchases. Even though canned goods may be bought at a discount in large quantities, it may not be profitable to invest hospital funds for a long time purchase, if the money is needed elsewhere or must be borrowed to make the purchase. Past experience is usually a helpful guide in deciding quantity and, here again, the information gained from reliable salesmen as to market trends is useful.

The type of markets, frequency of delivery and ease of obtaining supplies are other factors to be considered in determining quantity.

The methods of buying vary somewhat and in some instances are dictated by the administration. There must be competition among suppliers for the buyer to get the best results. Competitive bids either written or oral may be obtained, either for spot purchase or to cover a specified length of time. Detailed specifications require the suppliers to bid on items of comparative quality but proper receiving is the check necessary to ensure this procedure. The details of delivery and payment should also be understood by the bidders. Bids should be obtained from at least three, but not more than seven, suppliers unless the quantity and variety of items needed are extremely large. When orders are too small and divided among too many suppliers, delivery costs are higher and the dealers lose interest in the account.

The method of issuing requisitions for purchases is usually set up by the business office. At least three copies must be made, one for the supplier, one for the receiving agent from whom payment is made and one for the buyer's files. Such requisitions should state quantity, quality or description, size, count, weight or unit, price, terms of delivery and terms of payment.

Since the actual receiving of goods is usually the responsibility of someone other than the buyer, this informative requisition is necessary if he is to accomplish his task intelligently. A conscientious receiving clerk is a vital part in any purchasing setup. Weights must be checked, items must be counted and quantities must be compared with samples to ensure that the delivered item is identical with that specified on the purchase order.

The dietitian's interest should not end with the receiving of goods inasmuch as the institution's reputation for prompt payment of bills is reflected in a more favored position for her in making future purchases. Discounting bills also saves considerable money.

A careful record of petty cash transactions is highly important as the buyer must at all times guard against any loss through careless handling of funds.

Two of the attributes most difficult for the dietitian buyer or any buyer to acquire are: (1) how to eliminate personalities in the buyer-seller relations; (2) how to develop sales resistance and yet keep an open mind with regard to usable new items and special buys.

It is best for the buyer "never to be forced to buy"; that is, she maintains an advantageous position as a buyer only when she buys routinely and cautiously according to her needs and not hurriedly and frantically because she finds the goods are unexpectedly needed for an emergency.

To be a good buyer, the dietitian must be interested in this phase of her work; she must be given enough time and clerical assistance to carry out this task properly, and she should have the necessary technical information available through consultation at all times.

Contamination Hazard Reduced

More is being heard about the use of germicidal lamps in preventing contamination of food by dangerous bacteria. Air borne bacteria and microorganisms are responsible for substantial losses in restaurants today, it is said on good authority. When tubes of the proper characteristics are employed and the installation is made under competent engineering auspices, ultraviolet will help greatly. Certain of these tubes will even reduce odors. Perhaps the place where they are of greatest benefit is in refrigerators in which perishable foods are kept. Refrigeration alone will not prevent slime, mold or shrinkage. Indeed, the lower the temperature, the greater the shrinkage caused by dehydration. Here is where ultraviolet helps. Not only does it prevent bacteria from forming on meats, and the resultant mold and slime, but it permits operation at higher temperatures, cutting down shrinkage and helping the enzymes to ripen, which makes the meat tenderer and more flavorful.

Nutritional Requirements of Children

BERTHA M. SMYERS

Dietitian
Hillcrest Memorial Hospital
Tulsa, Okla.

AN ADEQUATE diet for the infant and the child through the period of growth is important and constitutes one of the major phases of pediatric care.

The variation between the age groups appears to be accounted for principally by the difference between the requirements of the growing organism and those of the fully developed one and by their respective differences in response to nutritional deficiencies. Continued growth and development are requirements of the healthy infant and child and, when they are retarded, supply a clear indication that the child is under par.

Result of Dietary Deficiencies

Although infections and metabolic diseases may cause a severe state of malnutrition, many nutritional disturbances among infants and children are the direct result of dietary deficiencies. These differences are both quantitative and qualitative. Not only do infants and children require proportionately more calories than do adults but the younger the child the greater the amount of water needed per kilogram of body weight.

Protein must be supplied in relatively greater amounts for the building of new tissue; iron, for the formation of hemoglobin and the constantly increasing number of red blood cells, and calcium and phosphorus, for bone growth. Because of the greater need for the various food elements for infants and children, there is the greater likelihood of manifestations of most of the nutritional deficiencies in the younger age group.

Nutritional edema from protein deprivation, ketosis from starvation, osteoporosis from inadequate intake of calcium and phosphorus and anemia from iron deficiency, all are produced in children by a relatively lesser degree of deprivation and in a shorter time than they are in adults.

The vitamin requirements are not qualitatively different for infants and children, but the clinical evidence of deficiency in children tends to show a different pattern from that shown by deficiency in the adults.

Infantile scurvy is quite different from the adult scurvy; beriberi and pellagra produce clinical manifestations in infants distinct from those they produce in adults.

Nutritional problems among infants and children are not limited to providing an adequate dietary intake for the various age groups; the psychologic problems associated with the feeding of modern infants and children are equally important. These are, as a rule, difficulties which have their origin in the older members of the family; their solution, therefore, requires consideration of both child and parent.

Because of a rapid growth and active energy exchange, the infant requires approximately 115 calories per kilogram or from 50 to 55 calories per pound of body weight per day during the first three months of life. The amount gradually decreases to approximately 100 calories per kilogram per day by the end of the first year of life.

Protein requirements in infants and children amount to more per unit of body weight than do those of adults because children must retain considerable quantities of nitrogen for the purpose of building new body tissue. Both human milk and cow's milk contain sufficient quantities of essential amino acids and protein percentage to provide adequate growth during infancy.

The proteins in human milk are considered biologically superior to those of cow's milk. Protein requirements for a breast-fed baby are from 2.0 to 2.5 grams per kilogram of body weight and are sufficient for adequate growth. Artificially fed infants require approximately 40 per cent more protein, or from 3.0 to 3.5 grams per kilogram of body weight. Premature infants require more protein per unit of body weight owing to their rapid growth. Carbohydrates afford the principal source of energy for the infant.

Monosaccharides, disaccharides and dextrins are readily assimilated by the infant. Starch is not digested during the early period of infancy. Carbohydrates should supply approximately 50 per cent of the caloric needs of the infant. Fat is an important source of energy both from direct consumption and also from utilization of that stored in the body tissues.

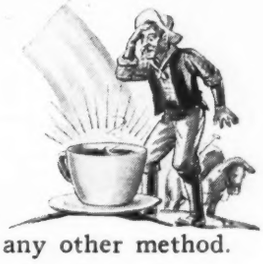
Form Good Habits Early

During the second year as much care is required in feeding as during the first year. The fear of the second summer would largely be overcome if the child were not allowed to eat foods unsuited to his digestive powers. The way to form good eating habits in the small child is to give him the proper diet and encourage him to learn to eat the various foods by tasting foods which are attractive in both their preparation and serving. It is a fact that some children do thrive on almost any kind of food, but at the same time caution should be used. One should not permit a child indiscriminately to have the same food as his elders, as is so often done.

It is extremely important that the child's training in good food habits should begin during the first year and continue through childhood. The meal hour should be one of

Leo Wertheimer

We Discovered a Gold Mine in a Cup of Coffee



It was during the early days of the now universally accepted Amcoin All Glass Coffee Making System.

We had just completed a demonstration for one of the large restaurant chain operators at the Restaurant Show in Detroit.

Robert G. Jahrling, proprietor of the Highland Hotel, Springfield, Massachusetts, turned to me when it was over and said: *"Leo, you have discovered a gold mine in a cup of coffee."* That was in 1925.

* * *

The vein of gold Amcoin discovered in a cup of coffee for the restaurants of America has great significance for every hospital.

Amcoin equipment creates a pot of gold on coffee alone equal to its own cost every nine to twelve months.

"Making the World's Best Cup of Coffee at Greater Profit since 1925"

It produces 25 per cent more coffee from every pound than does any other method.

It shows an extra saving by reducing cream consumption as much as 20 per cent.

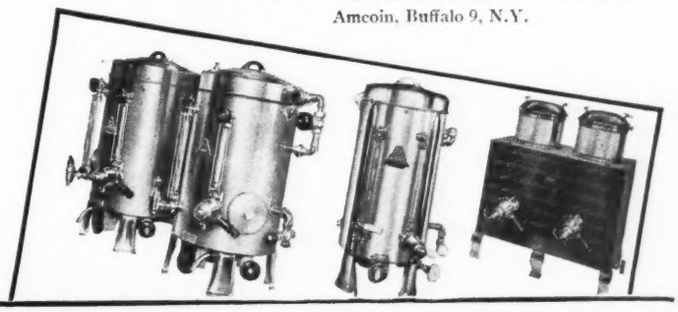
Better coffee is better therapy for patients whose appetites are touchy and particular.

The Amcoin prospectus tells you why and how—won't you let me send it to you.

AMCOIN

Leo Wertheimer

Amcoin, Buffalo 9, N.Y.



peace and quiet. Tension and unpleasantness during the meal hour will often destroy the child's appetite and quite frequently cause indigestion. His meals, three times a day, not only give the mother an opportunity for visiting with her child but also offer an opportunity to implant respect for good food and desirable habits of eating and manners as well as proper food tastes.

It is best to put one dish only before the child rather than the whole meal. The child has a "single track" mind and should, therefore, not have his interest in one food distracted by another which may be more attractive if not so essential. The foods should at least be served in courses, each one being a surprise. An unfamiliar food should come early in the meal while the child is still hungry and should be given in small quantities. Unfavorable comments regarding wholesome food should be strictly avoided.

During second year feeding the daily basic diet should include at least 1½ pints of milk; one egg, meat or fish; several vegetables, preferably one white and one green; fruits; butter; bread; from 4 to 6 ounces of citrus fruit juices, and from 5 to 10 drops of a fish liver oil concentrate. Extremely sweet or highly seasoned foods should be avoided. Vegetables chopped to a moderately coarse state, cream or cottage cheese, spaghetti, suitable raw vegetables and ice cream may also be added. Usually, a healthy child's natural appetite is the best gauge in regard to the quantity of food.

The child should be served three meals a day and, in addition, should have a midafternoon serving of fruit or a glass of fruit juice and a cooky. Milk should always form the basis of the diet. It is wise to use pasteurized milk, especially in cities. If the child has a tendency to constipation, oatmeal gruel is added. The gruel should be freshly prepared at each feeding.

In selecting children's food, the following suggestions are made:

Cereals: cooked oatmeal, cracked wheat, cream of wheat, rice, grits.

Bread Stuffs: stale bread, toast, zwieback or crackers. These may be given dry or with milk.

Vegetables: carrots, asparagus, mashed or baked potatoes, spinach, peas, puréed string beans.

Fruit Juices: orange juice, strained applesauce or prune pulp.

Broths: chicken, beef with cereal cooked in it or thickened slightly with wheat flour.

Eggs: coddled (once or twice a week).

If the child wakes early, he should be given either orange juice or milk. The child's feeding should be scheduled at fixed hours day in and day out, and he should be taught to eat slowly and to chew food well.

If possible, some older individual should always be present to see that sufficient time is taken for the meal. It is most important that correct eating habits be formed while young for many of the gastrointestinal disturbances attributed to teething are the result of improper feeding.

A suggested menu for one day is as follows:

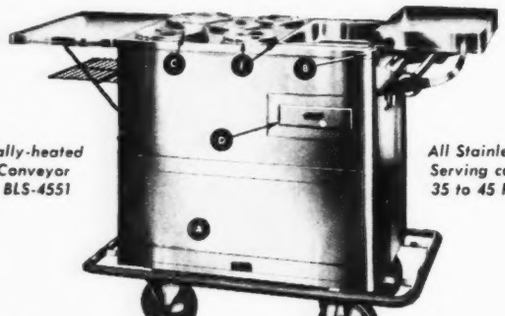
Breakfast: fruit, cereal, egg, slice of bread, milk; *lunch:* meat or fish, toast or zwieback, potato, green vegetable, fruit for dessert, milk; *dinner:* cheese, soup, egg or cereal, slice of bread, one vegetable, fruit for dessert, milk.

Facts for FOOD CONVEYOR Buyers

No. 2 OF A SERIES

Materials, construction, finish--the key to better sanitation

• **In comparing the sanitary qualities of different food conveyors, it is important to consider *all* these three factors. Mere surface appearance is not a reliable guide. In the previous advertisement, we described how the use of high-grade stainless steel helps sanitation. Here we give further details showing how "Conqueror" construction and finish assure hospital-standard cleanliness.**



Electrically-heated Food Conveyor Model BLS-4551

All Stainless Steel Serving capacity, 35 to 45 Patients

A. High protective polish—All stainless steel surfaces are given a high polish instead of just a sanded ground finish. This reduces adhesion of food and dirt, makes cleaning easier and enhances the corrosion resistance of the stainless steel.

B. Smooth, continuous corners—Corners of top deck are rounded, welded and polished to form a smooth continuous surface with the top and rim. No separate corner pieces used — no crevices to catch food and dirt.

C. Tightly-sealed utensil covers—Top and bottom parts of stainless steel covers are welded together, without openings or crevices. This prevents food or dirt from getting in and also protects the internal insulation against moisture.

D. Inside of drawer completely polished—High polish makes cleaning easier. The channel slides on which the drawer operates, as well as the drawer itself, are made of sanitary stainless steel.

E. Seamless, crevice-free food insets—All cylindrical and rectangular containers have fully-rounded corners for easy cleaning. Made of stainless steel for maximum sanitation.

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Conqueror

THE FINEST FOOD CONVEYORS MADE

EST. 1889

S. Blickman, 1504 Gregory Ave., Weehawken, N. J.

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Does the brand you serve meet your dietary standards?
Is the quality high, the flavor delicious?
Are you paying the lowest possible price?

Only if you are making your own ice cream with a Mills Counter Freezer can you answer all of these questions affirmatively. In no other way can you maintain your own control of nutrition values, purity, and flavor. *And in no other way can you keep costs so low.* With a Mills Freezer, you can have the highest possible quality at the lowest possible cost to you.

Neither the investment in equipment nor the labor of manufacture is great. The returns in ice cream quality, patient satisfaction, and hospital prestige are exceedingly high.

May we tell you more about Mills Ice Cream Equipment?

Mills Industries, Incorporated

Dept. 519, 4100 Fullerton Avenue, Chicago 39, Illinois

MAKERS OF MILLS MASTER ICE CREAM FREEZERS AND HARDENING CABINETS

Menus for May 1947

Emma L. Paquin
Woonsocket Hospital
Woonsocket, R. I.

1
Apple Juice
Poached Eggs, Toast
•
Pea Soup
Baked Ham, Raisin Sauce
Candied Sweet Potatoes
Mustard Greens
Coleslaw
Cottage Pudding, Lemon Sauce
•
Tomato Soup
Frankfurt and Roll
Relish
Tossed Vegetable Salad
Green Gage Plums
Sugar Cookies

2
Stewed Rhubarb
Fried Eggs, Toast
•
Quahaug Chowder
Broiled Haddock Fillet
Lemon Butter
Mashed Potatoes
Succotash
Keiffer Pear and
Cottage Cheese Salad
Mixed Gelatins,
Custard Sauce
•
Vegetable Soup
Potato Salad With
Deviled Eggs
Hot Cornbread
Blueberry Pie

3
Prune Juice
Scrambled Eggs
•
Cream of Potato and
Parsley Soup
Meat Loaf, Gravy
Hashed Brown Potatoes
Fresh Spinach
Hearts of Celery
Caramel Cream Pudding
•
Chicken Broth and Rice
Creamed Chipped Beef
on Boiled Potato
Green Salad
Cinnamon Buns

4
Half Grapefruit
Boiled Eggs
•
Tomato Juice
Broiled Veal Chops
Baked Potatoes
Fresh Green Beans
Radish Roses, Ripe Olives
Ice Cream
•
Vegetable Soup
Chicken Salad
Potato Chips
Sweet Mixed Pickles
Orange Cake

5
Blended Fruit Juice
Fried Eggs, Toast
•
Cream of Asparagus Soup
Pot Roast,
Jardiniere Sauce
Mashed Potatoes
Diced Carrots With
Parsley Butter
Coleslaw
Grapenut Custard
•
Beef Bouillon
Baked Macaroni and
Cheese
Cold Cuts
Tossed Green Salad
Cherry Cobbler

6
Stewed Apricots
Scrambled Eggs
•
Tomato-Rice Soup
Croquettes With Cream
Sauce
Mashed Potatoes
Peas
Pickled Beet and Egg
Salad, French Dressing
Hot Devil's Food,
Foamy Sauce
•
Vegetable Broth
Grilled Cheese Sandwich
Lettuce, Tomato and
Cucumber Salad With
Oil and Vinegar Dressing
Prune Pie

7
Orange Juice
Poached Eggs on Toast
•
Fruit Juice
Corned Beef
Boiled Potatoes
Whole Carrots
Buttered Beets
Cabbage, Pepper Rings
and Scallion Salad,
French Dressing
Whipped Orange Gelatin,
Custard Sauce
•
Beef Bouillon
With Noodles
French Toast
Criso Bacon
Jellied Peach Mold,
Mayonnaise
Raspberry Sherbet

8
Grapefruit Segments
Fried Eggs, Toast
•
Tomato-Vegetable Soup
Chicken Fricassee,
Parsley Potatoes
Fresh Wax Beans
Fruit Salad
Ice Cream and
Macaroons
•
Cream of Celery Soup
Sliced Ham
Potato Salad
Chow Chow
Pickles
Spice Cake

9
Stewed Prunes
Poached Eggs on Toast
•
Clam Chowder
Broiled Fillet of Cod,
Lemon Wedge
Mashed Potatoes
Spinach
Sliced Cucumber and
Radish Salad
Cornflake Cream Pudding
•
Tomato Juice
Creamed Salmon on
Hot Biscuits
Pear, Cherry, Cottage
Cheese Salad
Frosted Cup Cakes

10
Grapefruit Juice
Scrambled Eggs
•
Consommé
Roast Pork, Applesauce
Browned Potatoes
Creamed Parsley
Carrots
Sliced Tomato and Onion
Salad
Peach Shortcake With
Whipped Cream
•
Vegetable Juice
Baked Beans
Cold Meat Loaf
Pepper Relish
Lettuce Salad
Fruit, Cookies

11
Sliced Bananas and Cream
Fried Eggs
•
Cranberry Juice
Roast Turkey, Dressing
Mashed Potatoes and
Gravy
Diced Yellow Turnips
Molded Cranberry and
Mint Salad
Pumpkin Pie
•
Tomato Bouillon
Turkey à la King on Rusk
Tossed Vegetable Salad,
Russian Dressing
Strawberries and Fresh
Pineapple

12
Orange Juice
Poached Eggs on Toast
•
Lentil Soup
Swiss Steak With Gravy
Parsley Potatoes
Harvard Beets
Prune, Cream Cheese and
Nut Salad
Baked Bread Custard
•
Chicken Broth and Rice
Fresh Asparagus on
Toast, Cheese Sauce
Jellied Vitamin Salad
Watermelon

13
Half Orange
Boiled Eggs
•
Vegetable Juice
Baked Ham, Pineapple
Slices (broiled)
Delmonico Potatoes
Peas
Cucumber and Radish
Salad
Gingerbread With
Whipped Cream
•
Vegetable Soup
Fruit Salad,
Cream Dressing
Parker House Rolls
Lemon Chiffon Pie

14
Grapefruit Juice
Poached Eggs on Toast
•
French Onion Soup
Chicken Pie
Cranberry Sauce
Broccoli, Hollandaise
Sauce
Vanilla Fudge Ice Cream
•
Cream of Celery and
Parsley Soup
Corn Fritters,
Orange Sauce
Crisp Bacon
Fresh Fruit Salad
Creamy Rice Pudding

15
Apricot Nectar
Fried Eggs
•
Cream of Potato Soup
Boiled Mutton,
Caper Sauce
Browned Potatoes
French Green Beans
Apple and Cabbage Slaw
Cherry Cobbler
•
Chicken Noodle Soup
Club Salad
Liverwurst
White Cake, Mocha
Frosting
Canned Plums

16
Pineapple Juice
Fried Eggs
•
Tomato Bouillon
Baked Stuffed Bluefish
Parsley Potatoes
Pickled Spiced Beets
Green Salad,
French Dressing
Orange Cake Pudding
•
Fish Chowder
Toasted Lettuce and
Tomato Sandwich
Fresh Fruit Cup
Vanilla Wafers

17
Baked Apple With Cream
Poached Eggs
•
Blended Fruit Juice
Baked Sausages
Mashed Potatoes
Julienne Carrots
Asparagus and Sliced Egg
Salad
Cottage Pudding,
Pineapple Sauce
•
Vegetable and Rice Soup
Assorted Sandwiches
Mixed Pickles
Green Salad
Chocolate Blancmange

18
Half Grapefruit
Boiled Eggs
•
Tomato Juice
Broiled Steak,
Mushroom Sauce
French Fried Potatoes
Buttered Cauliflower
Hearts of Celery, Olives
Frozen Pudding Ice Cream
•
Cream of Celery Soup
Hot Chicken Sandwich
Orange and Grapefruit
Salad, Cream Dressing
Sponge Cake

19
Kadota Figs
Scrambled Eggs
•
Alphabet Soup
Beef Stew, Dumplings
Fresh Spinach
Spiced Peach, Cottage
Cheese Salad
Lemon Snow Pudding,
Custard Sauce
•
Cream of Mushroom Soup
Fresh Vegetable Salad
Potato Chips
Baking Powder Biscuits
Apricot Pie

20
Orange Juice
Fried Eggs
•
Green Split Pea Soup
Roast Lamb With Gravy
Creamed Parsley Potatoes
Wax Beans
Minted Fruit Salad
Rhubarb Strudel
•
Vegetable Juice
Chow Mein, Crisp
Noodles, Steamed
Rice
Lettuce Wedge,
1000 Island Dressing
French Bread
Coffee Gelatin With
Whipped Cream

21
Stewed Prunes
Poached Eggs on Toast
•
Mulligatawny Soup
Braised Liver With
Vegetables
Mashed Potatoes
Dill Pickles
Jellied Fruit Salad
Lemon Sherbet
•
Corn Soup
Ham Omelet
Pan-Fried Potatoes
Spring Vegetable Salad
Applesauce

22
Stewed Apricots
Fried Eggs and Bacon
•
Tomato Soup
Porcupine Meat Balls
With Gravy
Mashed Potatoes
Kernel Corn
Butternut Pudding
•
Cream of Spinach Soup
Grilled Frankfurters
Lyonnaise Potatoes
Pineapple Coleslaw
Hermits

23
Stewed Rhubarb
Poached Eggs on Toast
•
Clam Chowder
Broiled Mackerel,
Lemon Wedge
Mashed Potatoes
Julienne Beets
Lemon Gelatin
With Light Cream
•
Mixed Vegetable Soup
Codfish Balls, Creole Sauce
Waldorf Salad
Baked Coconut Custard

24
Blended Fruit Juice
Scrambled Eggs
•
Vermicelli Broth
Roast Veal With Gravy
Creamed Potatoes
Fresh Asparagus
Carrot and Raisin Salad
Glorified Rice
•
Celery Broth
Baked Kidney Beans
Cold Cuts
Shredded Lettuce,
Roquefort Dressing
Pears au Gratin,
Lemon Sauce

25
Tomato Juice
Boiled Eggs
•
Pineapple Juice
Prime Roast of Beef
With Gravy
Horse Radish and
Celery Curls
Baked Stuffed Potatoes
Buttered Broccoli
Banana-Nut Ice Cream
•
Chicken Gumbo
Potato Salad Garnished
With Tomato Wedges
and Crisp Bacon
Hard Rolls
Marble Cake

26
Prune Juice
Fried Eggs
•
Clear Consommé
Meat Pie With Mashed
Potato Topping
Sliced Tomato and Egg
Salad, Vinaigrette
Dressing
Apricot Roll, Nutmeg
Sauce
•
Cream of Tomato Soup
Chicken Salad, Roll
Celery and Olives
Strawberries
and Cream

27
Grapefruit Segments
Scrambled Eggs
•
Pea Soup à la Canadienne
Broiled Liver and Onions
Escalloped Potatoes
Stewed Tomatoes
Chef's Salad
Rhubarb Betty
•
Vegetable Soup
Baked Hash With
Poached Egg
Diced Cucumber and
Radish Salad,
French Dressing
Apple Pie and Cheese

28
Sliced Bananas and Cream
Poached Eggs
•
Blended Fruit Juice
Roast Chicken, Dressing
Mashed Potatoes
With Gravy
Butternut Squash
Stuffed Celery
Baked Indian Pudding,
Whipped Cream
•
Noodle Soup
Curried Lamb and Rice
Green Salad
Red Plums, Cookies

29
Half Orange
Boiled Eggs
•
French Onion Soup
Hamburger Roll With
Mushroom Sauce
Parsley Potatoes
Cabbage au Gratin
Pickled Beet and Pepper
Ring Salad
Chocolate Tapioca
•
Chicken Broth
Creamed Chicken in
Patty Shells
Quartered Tomatoes
Butterscotch Chews

30
Apple Juice
Pancakes, Maple Sirup
•
Rhode Island Clam
Chowder
Fresh Salmon Steak,
Lemon Butter
French Fried Potatoes
Garden Peas
Asparagus Tips and
Pimiento Salad
Pineapple Sherbet
•
Tomato Bouillon
Tuna Salad, Roll
Olives and Pickles
Washington Cream Pie

31
Orange Juice, Fried Eggs • Cream of Pea Soup, Broiled Lamb Chops, Mint Jelly, Candied Sweet Potatoes, Grilled Tomatoes, Tossed Vegetable Salad, Floating Island • Vegetable Soup, Mushroom Omelet, Molded Fruit and Cream Cheese Salad, Pecan Rolls

Ready-to-eat or cooked cereals are offered on all breakfast menus.

New Food Tips for Dietitians

QUANTITY RECIPES - MENU HELPS

PEACH CRISP DESSERT

Crunchy cereal and sun-sweetened California peaches make this simple pudding a popular item! 48 servings

	Weight	Measure
Sliced canned cling peaches		5 quarts
Brown sugar	2 pounds	1 quart packed
Sifted all-purpose flour	8 ounces	1 pint
Finely crushed corn flakes	8 ounces	1 quart
Nutmeg		2 teaspoons
Salt		2 teaspoons
Butter or margarine	1 pound	2 cups

Drain peaches before measuring; arrange slices in 2 shallow greased pans (approximately 10 x 18 inches). Blend together dry ingredients. Cut in butter until mixture is texture of coarse corn meal. Sprinkle over peaches. Bake in moderately hot oven (375° F.) 25 minutes. Serve warm or cold with cream.

How plump, sun-sweetened California Canned Cling Peaches help hold your cooking costs down

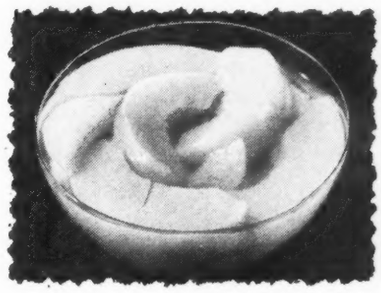
Penny-saver peach tarts: Butter a slice of fresh bread and press into greased muffin tin to form cup. Place peach half, cup side down, on bread. Bake 10 minutes, or until fruit is heated through. Serve warm with sauce made of peach syrup, slightly thickened and sweetened; add lemon rind for flavor.

Cake saver: Thicken canned fruit cocktail with cornstarch. Serve warm over pound cake or simple pudding.

Sugarless ginger-peach pudding: Place peach half, cup side up, in greased custard cup. Over it pour your favorite gingerbread batter. Bake in moderate oven (350° F.) 40 minutes. Serve with peach on top. Decorate with whipped cream.

Meat loaf money maker: Brush peach halves with butter or margarine. Spread with zippy catsup. Broil until peaches are heated through and top bubbly. Good with Salisbury.

Sunshine eggnog: Mashed canned peaches give milk drinks a new mellow-rich flavor.

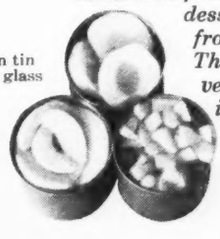


They're wonderful so many ways!

California Cling Peaches

Canned Halves · Canned Slices · Canned Fruit Cocktail

In tin or glass



California Cling Peaches ripen lazily in sun-drenched valleys. They're sweet, tender, golden yellow. America's favorite easy dessert right from the can. Thrifty, convenient, popular in salads, baking, garnishes, too! Make sure the label says "clings"!

PLANT OPERATION & MAINTENANCE

Ten Ways to S-t-r-e-t-c-h

the Dollars Spent for Lubricants

ERNEST W. FAIR
Bristow, Okla.

MOST cases of excessive lubrication costs occur in institutions in which there is either too much carelessness or a lack of knowledge of how to get the most out of the lubricants," a lubrication authority stated recently. "Far too many of us look on lubrication as being a matter of just having a can of oil or grease around somewhere and using it when bearings start to howl," he continued.

"That's all wrong! There are many ways of making lubrication more economical and many short cuts that can be practiced to keep down lubrication costs."

Because there is hardly a hospital administrator in the land who is not interested in saving dollars on his yearly lubrication bill, if he can do it safely, I asked for some of these pointers and short cuts. This authority supplied a number of suggestions and to these I have added ideas offered by other lubrication experts and a number that are being used by hospitals.

Together these ideas form a handy guide that can well be posted in every hospital for the guidance not only of the management but of every employe who maintains the equipment in that institution or who uses it in actual day to day operations.

Store lubricants correctly. Too much of the waste of lubricants occurs in their storage. It is never advisable to keep lubricants just any place. A cabinet in which all of the lubricants can be stored should be installed and kept under lock and key. This should be built in a spot that is not too warm and that has a free circulation of air.

Handle lubricants carefully. Lubricants are not so inexpensive that they can be thrown around carelessly. Proper equipment for their application should always be used; sticks or cheap funnels only waste oils and greases. The lubricant should be kept inside of the container and not wasted by being allowed to drip over the side of the can, bottle or jar. Containers should also be handled carefully, for a can of oil spilled on the floor cannot be reclaimed.

Don't overlubricate. Overlubrication is as dangerous in actual practice as is underlubrication. Every bearing, every shaft, every unit needing oil or grease requires just so much to operate efficiently; when that amount is exceeded there is nothing but pure waste because the extra amount of lubricant adds nothing whatever to its effectiveness as a whole. Whoever takes care of the lubrication of hospital machinery should know exactly how much oil or grease is required in each spot and use no more; if he does not possess such knowledge the hospital management should see that information is obtained from the equipment manufacturer.

Buy quality lubricants. No hospital manager ever stretched his lubrication dollars by trying to save on purchases of oils and greases; it pays to buy quality. Only in quality greases can the proper balance be obtained to do the job effectively. Numerous tests have proved that in nearly every instance quality lubricants last far longer than do inexpensive brands, do less damage to equipment upon which they are used and in the long run are less expensive.

Watch seasonal lubrications. Many lubrication dollars are being wasted owing to the false belief that there is not enough difference between summer and winter lubricants to justify their purchase. If the hospital is located in an area where the weather ranges in extremes of temperature up and down the thermometer, it will pay the administrator to discuss the problem with his supplier. Economical use of lubricants calls for their use at the point of their highest efficiency; a summer lubricant is not always efficient in winter, and vice versa.

Use special lubricants where they are needed. Sometimes it will be more economical from the standpoints of decrease in breakdowns and higher production, as well as longer useful life of equipment, to investigate the use of special lubricants adapted for specific purposes. Other points to be checked are areas where water is used in quantity or locations where motors operate near extreme heat. A special lubricant will usually protect the equipment

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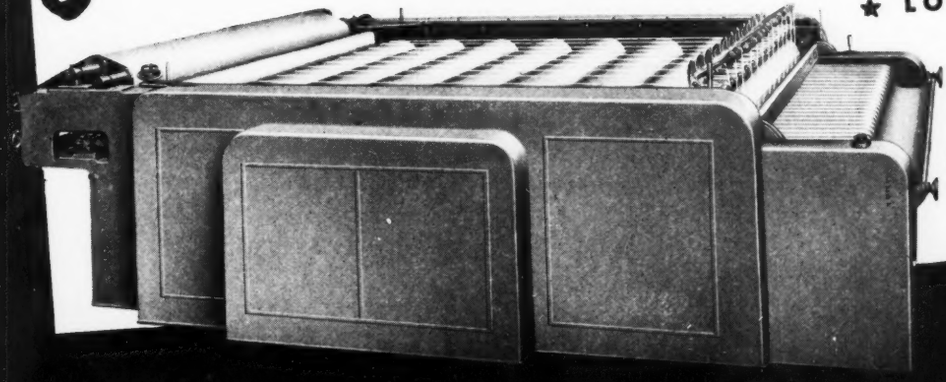

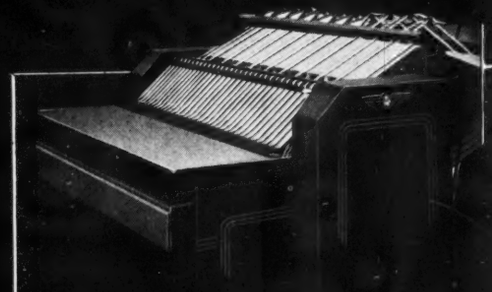

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longer in most such spots and thus save money even though it costs more than does a general overall lubricant.

Buy in quantity if possible. Discounts can be obtained through the purchase of other supplies in quantity; why not lubricants? The answer lies either in the hospital's having a proper space in which to store them so that there will be no loss through deterioration, or in the creation of a buying pool with other institutions in the area. Quantity buying is another good way of stretching lubrication dollars.

Train someone to do the job right. It is common practice in far too many institutions to turn the lubrication of expensive machinery over to just anyone, and that is not a good practice even in a small hospital. Whoever does the job should know that he is responsible for it; should take his job seriously enough to be ever on the alert for ways of doing it better. No effort expended toward economizing on lubricants will be effective if oil and grease are permitted to be handled haphazardly in the institution itself.

Be on the alert for new developments. New discoveries and improvements in lubricants and the proper methods of using them are constantly being made available to any lubricant user who wants them. Wise is the hospital manager who sees to it that these discoveries for more efficient use of lubricants are put into practice in his institution as soon as they are announced.

Make sure of bearing seals. Probably the most widespread waste in lubrication is through inattention to bearing seals on all types of equipment. No lubricant can be kept on the job for its own useful life when it is permitted to escape from its reservoir or container. It is profitable to check bearing seals constantly and make sure that the lubricant, after it is applied and used intelligently, is not wasted in this manner. The first sign of oil dripping beneath a bearing means a loose seal somewhere.

These are 10 lubrication stretching pointers which can be used in any hospital to the ultimate profit of that institution; they need only be applied both by the man who pays for them and by the man who uses them.

How the Army Saved Fuel

DURING the war civilians had a fairly hard time of it insofar as fuel for heating was concerned. Between strikes, the elements and increased demands for fuel, this problem almost reached a state of emergency. The adage "war is waste" is true, especially modern warfare. The best we who were caught in the course of the war could do was to strive for the conservation of all materials placed at our disposal until final victory.

The following is an account of how we in an A.A.F. Regional Hospital were able to cut maintenance costs and save fuel. We were located in the south central part of Arizona and found natural gas of 1000 Btu. per cubic foot to be the most economical and efficient fuel. Steam produced was of the following pressures:

High: (100 p.s.i.) carrying pressure of steam mains in order to lower condensate and to get as dry a steam as possible.

Medium: (25-40 p.s.i.) used for steam generating hot water heaters.

Low: (3-5 p.s.i.) for general heating.

The physical plant consisted of five locomotive fire boxes with gas burners; five automatically set water regulators connected one to each fire box and in turn to three duplex pumps, and 10 condensate vacuum pumps (twin sets).

As in similar institutions, we had peak periods on the steam system. Ours reached a maximum load of 300 h.p. between the hours of 6 a.m. and 9:30 a.m.

We had been using an average of from 2,500,000 to 3,000,000 cubic feet of gas per month. At current rates this represented a sizable expenditure and we considered it well worth investigating as to possible waste. J. A. Robinette, our chief operating engineer, did just that, and the results of his investigation follow:

1. This was Tucson, Ariz., where every day is comparatively warm, even in the winter, but the nights may warrant a top coat; consequently steam heat was required.

2. Although the heat was left on during the day in all buildings checked, some of the buildings had many open doors and windows.

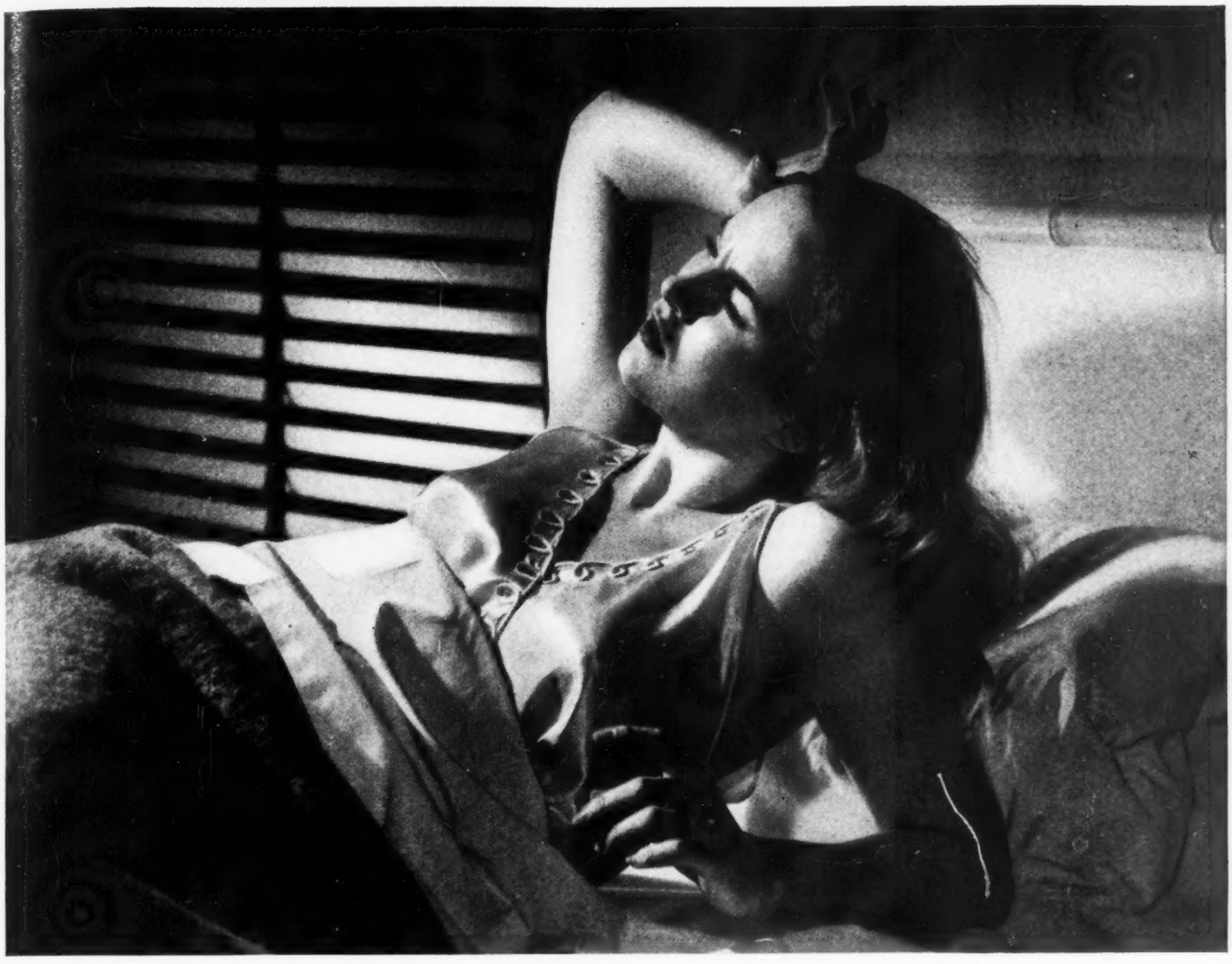
3. Few calls were received to turn the heat off, presumably because of the anticipated need for it in the evening. There probably was also a feeling that it would not be turned on readily when called for.

The engineering staff at the hospital consisted of three firemen and three maintenance mechanics, with the chief engineer supervising, in addition to his work of maintaining numerous other heating facilities about the base and three pumping plants.

To effect a reduction in maintenance costs the maintenance mechanic made rounds daily, when the weather made it practicable, and turned off the heat in each of the 46 buildings in the hospital group. This was done as soon as the outside temperature had risen to the point at which steam heat was no longer required. The only exceptions made were in the operating room and the x-ray departments, where a more nearly even and higher temperature was required. Unless circumstances required other action, the steam for heating was cut off during the entire day.

In the evening this steam was turned on at the request of the charge nurse or other department head.

A simple procedure, one might say, but highly effective and applicable to whatever type of fuel might be used. It was estimated on an inspection of consumption records that a saving of 45,000 cubic feet of gas per day was effected by this procedure, with no additional labor cost involved. Forty per cent saved is well worth while. —Robert B. Lloyd.



Noise GLARES *too!*

WHEN *light* glares—your eyelids automatically protect your eyes.

But when *noise* assaults your ears—you have no "earlids" to protect your ears. And in a hospital harsh noise is as "glaring" as harsh lighting—and as needless.

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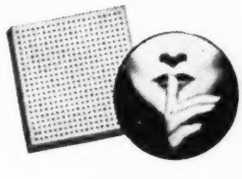

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HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

Stop Those Losses BEFORE They Start

THE minor losses that occur in a hospital during just one day, if added up, would startle many hospital administrators.

A program for control of these small but expensive "leaks" might very well begin and end at the door used by the employes, who should be assigned a special entrance and be permitted to use no other. A timekeeper should supervise the signing in and out of each worker. Separate time sheets—one for housekeeping department workers, one for dietary and one for laundry employes—could be used as a double check against the time books and held for reference in case a dispute develops at pay day. Time books should be filled in daily in ink.

The next step is to provide each employe with a locker and key. If these are furnished, stories of lost uniforms and belongings can be eliminated.

A deposit for all items issued by the hospital, such as uniforms, laundry bags and keys, should be required. and the final pay check should not be issued until an "all-clear" has been received from the housekeeper.

After the first uniform is issued to the worker, a clean one should be given only if the first one is returned soiled. Allowing a worker to take a clean uniform upon the mere promise to bring in the soiled one permits far too many loopholes.

A master key for all lockers should be available for the housekeeper's use and frequent inspection of lockers should be made.

No packages should be allowed to pass the timekeeper without inspection, either in or out. Laundry employes are inclined to bring in their own family wash. If they cannot get it into the hospital, time cannot be wasted in laundering it.

Next comes the matter of supplies. Locks should be furnished for the janitors' and maids' closets. Considerable saving can be made that way because the employes can then be held responsible for the materials issued them.

Working materials should be standardized, marked and listed, with a typewritten list put up on each closet door. A slat with hooks screwed into it is necessary so that each item can be hung up; the name of each article should be painted over its hook. If a standard setup is maintained in these closets and they are inspected each night, loss can be easily detected and prevented.

After minor routines for control of loss have been established, thought should be given to the larger issues, *i.e.* whether or not there is lack of efficiency because of unsystematic direction of duties.

The hospital policy on at just what point the housekeeping department is to meet the nursing service should be clearly defined. The outline of duties of each subsidiary worker should be debated by the heads of departments and a job analysis and time study should be worked out.

Abilities vary with the individual worker and for that reason it is best not to display the detailed job analysis and time study but to use a simplified version and bring the worker as near to schedule as possible. This simplified form should be typewritten and posted in the worker's closet on his division where it can be referred to easily.

With a definite knowledge of what is expected of each individual, the assistant housekeeper can then instruct employes intelligently. Emergencies caused by absence should be foreseen and arranged for. Through experience in meeting these situations, a definite program should be worked out so that confusion can be avoided.—FRANCES PENFIELD, *executive housekeeper, Bristol Hospital, Bristol, Conn.*

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8. Kem-Tone COSTS LESS PER JOB!
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NEWS DIGEST

Announcement of $160,000,000 Gift Highlights Texas Hospital Meeting

Announcement of a gift to Texas hospitals and educational institutions estimated at a minimum of $160,000,000 caused a sensation at the opening meeting of the Texas Hospital Association's annual convention in Houston the evening of March 27.

The gift was made by Mr. and Mrs. Hugh R. Cullen. Speaking at the hospital association's meeting on the subject "Why We Directed Our Philanthropies to Hospitals," Mr. Cullen, whose previous donations to hospitals have totaled more than $4,000,000, announced that he and Mrs. Cullen were creating a foundation in the form of oil properties containing approximately 80,000,000 barrels of oil estimated to be worth $2.10 a barrel. The foundation will provide aid for medical and educational institutions; according to Houston newspapers it is expected that the principal beneficiaries will be the Texas Medical Center and the University of Houston.

In his address, Mr. Cullen said, "Nearly all our great medical centers and hospitals and our great educational institutions have been built by private donations. There is no more worthy cause than caring for the suffering and sick and the disabled because every dollar given to hospitals is spent in the right way. Your profession is one of the noblest. In my opinion it is the basis of all our religions."

Thomas H. Head, business manager of Shannon West Texas Hospital, San Angelo, assumed the presidency of the Texas association at a banquet meeting Friday, March 28, taking over the office vacated by B. Tol Terrell of Harris Memorial Hospital, Forth Worth, who was elected a delegate to the American Hospital Association. R. O. Daughety, administrator of the Hermann Hospital, Houston, was named president-elect.

Other officers elected at the meeting were: vice president, C. J. Hollingsworth, administrator, West Texas Hospital, Lubbock; treasurer, W. H. Pigg, administrator, St. David's Hospital, Austin. Four trustees elected were: Lawrence Payne, administrator, Baylor University Hospital, Dallas; Mrs. Ruby Gilbert, administrator, King's Daughters' Hospital, Temple; Harold Prather, administrator, Nix Memorial Hospital, San Antonio; Julian H. Pace, administrator, Hillcrest Memorial Hospital, Waco.

In one of the principal addresses of the convention, John H. Hayes, president of the American Hospital Association, deplored the tendency of hospitals to ask too much of their Blue Cross plans, overlooking the great blessing which Blue Cross has brought to hospitals as well as to the public. Mr. Hayes urged hospitals to stop "loading" private patients' rates to carry losses sustained on ward patients.

In another address, Raymond P. Elledge, chairman of the board of trustees of the Methodist Hospital at Houston, stated that the responsibility of hospital trustees includes recognition of the tremendous difficulties under which hospital personnel is working today. Appreciation of these difficulties can only be shown through payment of adequate salaries, provision of suitable working conditions and retirement pensions, he said.

Meeting concurrently with the Texas Hospital Association, the Texas chapter of the American Association of Medical Record Librarians elected the following officers: President, Sister M. Paul, R.R.L., Santa Rosa Hospital, San Antonio; president-elect, Clara Schwabe, R.R.L., M. D. Anderson Hospital, Houston; vice president, Mrs. Dimple Lewis, R.R.L., John Sealy Hospital, Galveston; secretary, Mrs. Curtiss Watters, R.R.L., King's Daughters' Hospital, Temple; treasurer, Mrs. Eloise Odam, R.R.L., Hendrick Memorial Hospital, Abilene; councilors, Norah Smith, R.R.L., Parkland Hospital, Dallas, Mrs. Sara Fertsch, R.R.L., Methodist Hospital, Houston.

A.H.A. Votes $10,000 for Nurse Recruitment

In an effort to overcome the acute shortage of nurses, the A.H.A. plans an intensified student nurse enrollment program on a nationwide scale throughout 1947, it has been announced by John H. Hayes, association president.

Direct aid will be given to hospital schools of nursing, with a backdrop of national publicity, Mr. Hayes said. The association's board of trustees voted an expenditure of $10,000 for this campaign, and hospital schools of nursing and other organizations affected by the shortage of nurses are being asked to contribute financial help.

A kit of publicity materials for individual hospital use, special letters and bulletins and other recruitment aids will be prepared by the association staff, Mr. Hayes said.

Change in Wagner and Labor Relations Acts Sought by Hospitals

By EVA ADAMS CROSS

WASHINGTON, D. C.—The trustees of Johns Hopkins Hospital filed a statement March 18 with the House education and labor committee asking for a change in the Wagner Act which would relieve nonprofit hospitals from the necessity of dealing with labor unions. John H. Hayes, president of the American Hospital Association, also filed a statement urging an amendment to the National Labor Relations Act .

The trustees of Johns Hopkins Hospital declared the hospital does not have the economic power to bargain with a union of its employes. It depends on voluntary contributions from the community and from fees from some patients, according to the statement.

The only bargaining asset of the institution lies in the efficiency of its service to the sick of the community, said the trustees. It seems highly unethical and detrimental to the public welfare for this hospital to be compelled to bargain with a stated group or labor union which could, at will, exercise its power to disrupt service or strike if its demands were not granted, regardless of the hospital's ability to meet its demands.

Mr. Hayes said that the charitable nature of hospitals presents a unique situation which was not within the consideration of those who wrote the National Labor Relations Act. There are no profits, according to his statement, over which unions and management can bargain in the sense contemplated under the National Labor Relations Act.

Simplifications in VHP-1 Are Announced

WASHINGTON, D. C.—Among minor simplifications to VHP-1 and its supplements, announced March 20, is the exemption of movable partitions from the order. "Partitions, wood or metal" and "signs, electric and other" were deleted from restrictions of the order.

C.P.A. warned that authorizations under VHP-1 may not be transferred from one person to another. If a builder wishes to abandon a nonresidential project and another builder wishes to continue it, the new builder must apply for authorization.

VHP-1 has been on the books since March 26, 1946. No basic changes or relaxations in the order are contemplated.

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"Standing Room Only" at New England Hospital Assembly

Registration at the close of the second day of the twenty-fourth meeting of the New England Hospital Assembly passed last year's three day record, putting it well over the top in point of attendance. Interest in the extensive program presented was manifest by the fact that "standing room only" was the general rule in all the assembly rooms of Boston's Hotel Statler. General sessions, sectional meetings and exhibits shared equally. For added measure this year, President Donald S. Smith, superintendent, Mary Hitchcock Memorial Hospital, Hanover, N. H., inaugurated the first Trustee Institute to be held in the East. This alone attracted an audience of some 650, principally trustees of New England hospitals.

A wide variety of subjects was presented with more than 100 "specialists" participating, aided by panels, discussants and coordinators. Much of this discussion centered about the widening scope of general hospital service as recommended by the study of the Commission on Hospital Care.

New concepts of the tremendous need for providing adequate facilities for rehabilitation were presented by Dr. Howard A. Rusk, professor of medical rehabilitation, Bellevue Hospital, New York. According to Dr. Rusk, a million people entitled under the law to receive service are not getting it because of ignorance of the law and, in some cases, lack of facilities to provide care. He pleaded for suitable provision for convalescent care. This can be provided at 50 per cent of the cost of acute facilities. Furthermore, the patient can be maintained in a properly designed and executed program at 60 per cent of the cost of acute hospital care. "A real rehabilitation program," Dr. Rusk added, "pays off five to one in dollars and cents."

Startling facts regarding chronic alcoholics and the part that general hospitals should be but are not playing in the treatment of such patients stirred the New England audience visibly. An estimated 750,000 chronic alcoholics today are so physically or mentally injured by their sickness that they need hospitalization, Mrs. Marty Mann, executive director, National Committee for Education on Alcohol, explained. Mrs. Mann appealed to hospitals to accept alcoholics as sick people who can be cured.

Nursing problems, as might be expected, were discussed at length. Among other suggestions was one that the training of professional nurses be transferred to educational institutions, permitting hospitals to reserve their schools for the preparation of practical or attendant nurses. General discussion and debate revealed marked difference of opinion on the rôle played by the practical nurse and her training. Hilda M. Torrup, president, National Association of Practical Nurse Education, regretted the absence of any unified program of training or utilization of the country's 400,000 practical nurses and pleaded for training opportunities for women whose services are needed not only in hospitals but for home care under proper medical supervision.

Among those participating in the Trustee Institute was Robert Cutler, treasurer, Peter Bent Brigham Hospital, Boston, who discussed the difficulty of financing hospital services at the present time. Gifts to charities in the United States are rapidly declining, evidenced by a drop of 15 per cent this year from

(*Continued on Page* 156.)

Most Priority Ratings Ended With March, C.P.A. Announces

WASHINGTON, D. C.—Most priority ratings were eliminated March 31. Limited use will be made of ratings in support of the Veterans' Emergency Housing Program and for the construction of veterans' hospitals.

The action was accomplished by issuance of PR 35 which contains a new rating symbol "RR" and by changes in Priority Regulations 1, 3 and 28. All AAA, MM and CC ratings for any material or product other than a construction item expired at the end of March. None of these ratings will be issued for any purpose after April 1.

All production controls on lumber, millwork, hardwood flooring and softwood plywood were also removed at the end of March by the revocation of orders L-358 and L-359. Certain restrictions on deliveries of Douglas fir and Western pine shop lumber will be retained, however, according to C.P.A.

How Los Angeles Hospitals Handled Victims of Recent Plant Blast

Wartime disaster planning saved lives in Los Angeles hospitals following explosion of the O'Connor Electroplating Corporation plant there February 20, according to George E. Peale, assistant superintendent of the California Hospital, where 26 of more than 100 persons injured in the disaster were treated.

Other victims were cared for at the Queen of Angels, General, Good Samaritan, Santa Fe and Georgia Street Receiving hospitals.

Preparations to receive patients at the California Hospital got under way as soon as the terrific blast shook the hospital building, before hospital authorities knew what had happened, Mr. Peale reported. Operations were postponed or canceled as far as possible to clear the operating rooms for emergency service; 25 beds were moved into the hospital auditorium; doctors and nurses were alerted according to the previously rehearsed wartime team organization. The admitting department checked to determine what patients could be evacuated if additional space were required, but this proved to be unnecessary.

Beds in the auditorium were ready by the time the first patients were brought to the hospital, Mr. Peale said; those needing surgery were cleared to the operating rooms within ten minutes. Portable x-ray equipment, whole blood, plasma and other needed supplies were available for immediate use.

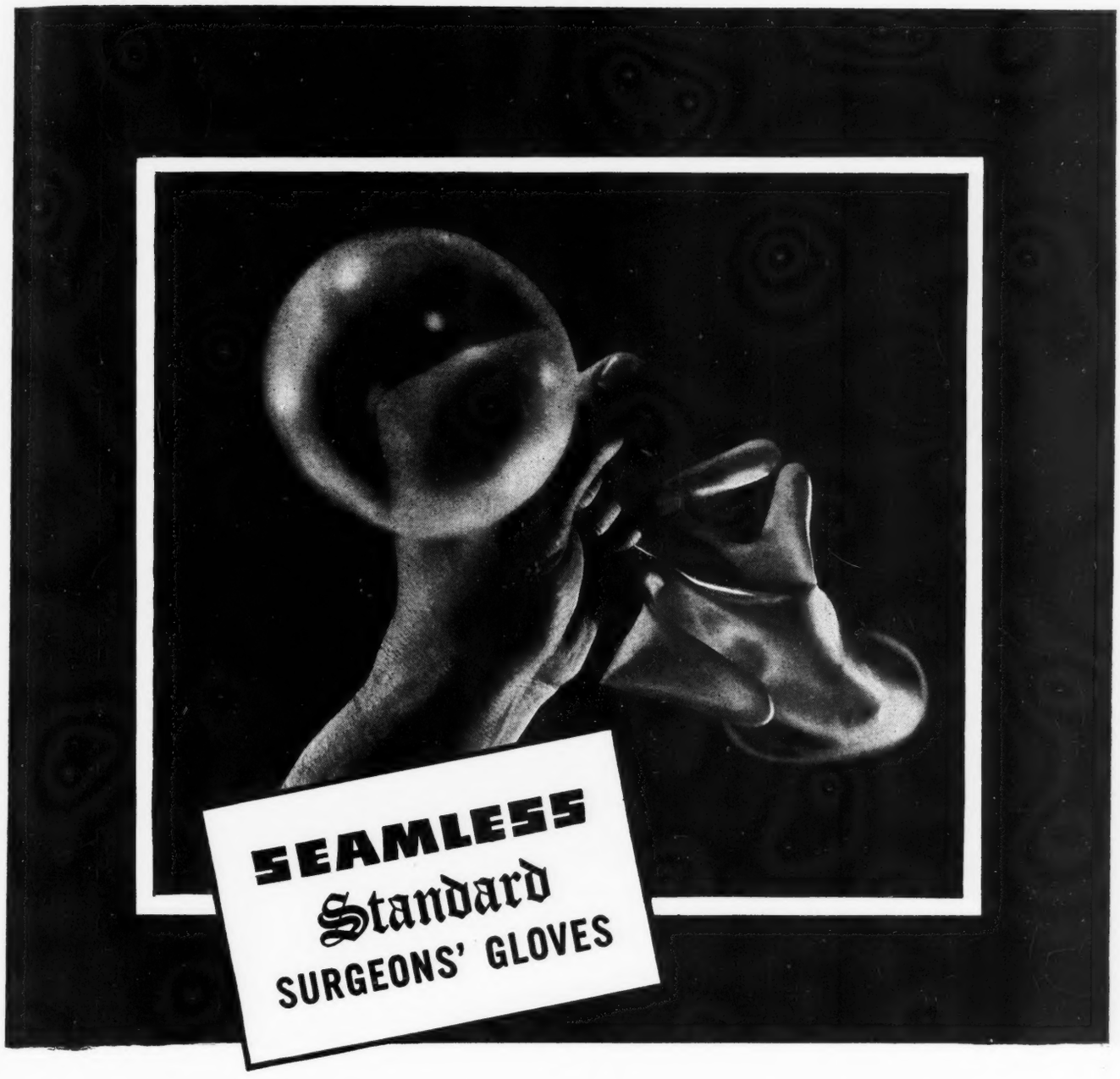
Patients were all tagged with previously prepared emergency forms providing minimum identification and treatment information, it was reported.

The Red Cross paid E.M.I.C. rates for patients not covered by workmen's compensation, Mr. Peale said. He added that in this case employment information on the patient's emergency tag would have proved helpful.

A similar plan for organizing treatment of the injured was carried out at the Good Samaritan Hospital, where 25 victims were taken, 10 of whom were admitted to the hospital as bed patients. Here space was the principal problem, since the hospital was already filled to the limit of its capacity. Through canceling other admissions and discharging a few patients, however, arrangements were quickly made for the blast injured to be cared for.

Treatment was given by house staff doctors in the regular emergency room and an adjacent waiting room and, later, in the operating rooms. The Good Samaritan patients were mostly compensation cases, as it turned out, and were referred to company physicians in each case after emergency care had been given by the hospital staff.

"So far as I am concerned," said Alden B. Mills, western editor of The MODERN HOSPITAL and administrator of the Huntington Memorial Hospital in nearby Pasadena, "this has taught me to dig out our own disaster plan and see that it is widely distributed in the hospital and fully understood by every employe and staff member."



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Hospital Industries Condemns Solicitation of Funds by Hospitals

The executive committee of the Hospital Industries' Association at a recent meeting approved a resolution condemning the practice of soliciting hospital donations from supplying firms.

The resolution follows: *"Whereas,* the American Hospital Association, the Canadian Hospital Association and the American College of Hospital Administrators, as well as the American Protestant Hospital Association, have placed themselves on record as being opposed to the practice of solicitation by hospitals of donations from manufacturers and suppliers, and

"Whereas, it is the sense of the Hospital Industries' Association that the voluntary hospital is a community enterprise and should derive its support from the citizens of the community it serves and from whatever federal or other governmental funds are provided, and

"Whereas, it is the sense of the Hospital Industries' Association that the general welfare of hospitals is of direct interest to it and that as individual members of the *communities in which their operations are conducted* it is their duty to lend their fullest support to hospitals serving those communities, but that donations to hospitals elsewhere, whether as a voluntary gesture or under a threat, expressed or implied, of patronage depending upon such donation, can only be considered as a direct sales cost affecting the price of commodities sold to hospitals, and

"Whereas, the Hospital Industries' Association believes that the best interests of all hospitals are served when the supplier provides the highest quality merchandise at the lowest possible price, sold on merit without regard to special favors, therefore

"Be it resolved: That the members of the Hospital Industries' Association emphatically condemn the solicitation of suppliers and manufacturers by hospitals for donations and consider the giving by suppliers and manufacturers of contributions to hospitals situated outside of the community in which the supplier is located to be definitely contrary to accepted business principles."

Virginia Gets Army Hospital

Woodrow Wilson General Hospital, near Staunton, Va., has been transferred by W.A.A. to the commonwealth of Virginia, for use as a rehabilitation center for disabled citizens. Fifty-two of the hospital's 158 buildings will be used by the state for the rehabilitation center and the remaining buildings will be used by Augusta County for school purposes.

"Yes Doctor... right away!"

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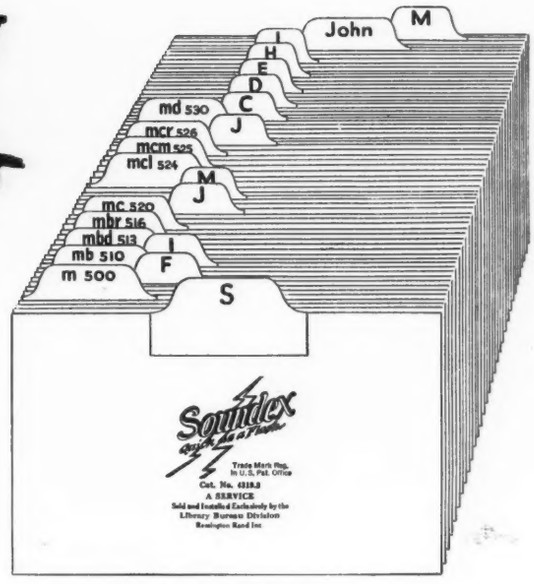

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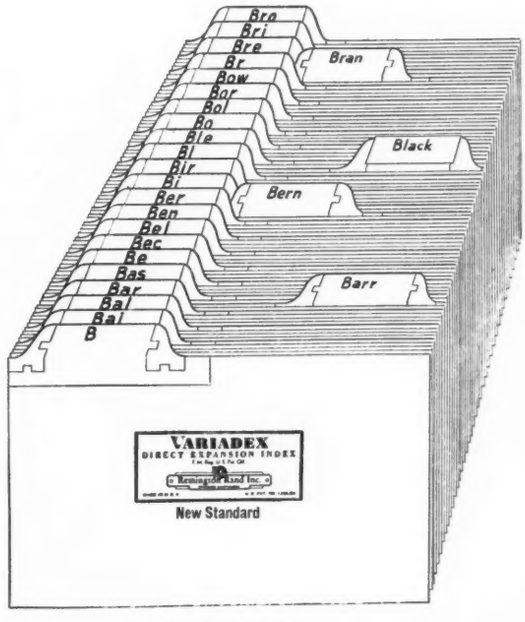

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Need for Support of Medical Schools Cited by 19 Universities

The future of medical care and public health depends upon medical education, and present medical school provisions for ensuring a continuing supply of well trained physicians are inadequate, according to a joint statement on medical education released by presidents of 19 universities on March 15.

The medical schools are inadequately supported in terms of future needs, the statement said. Few, if any, of the 70 recognized medical schools in the United States can be confident, with present resources, of maintaining their programs at the essential high level.

Forty-three of these 70 schools are maintained solely by income from private endowment, private gifts and tuition fees from students, it was pointed out. Many of the endowed schools are of the first quality; they furnish friendly competition in excellence for the best of the tax supported schools. They have set the pace for medical education. Even the 27 schools wholly or partly supported by taxes depend upon private sources for important parts of their programs, it was added.

As medical knowledge becomes more extensive, the costs of imparting that knowledge mount, the presidents explained. Most of the costs cannot be paid by the medical students and tuition fees are already as high as most students can pay. Expenses of medical schools run as high as $4500 or more per student per year. The costs which make up this total have constantly mounted and will probably continue to mount. Meanwhile, income from invested funds seems likely to remain low.

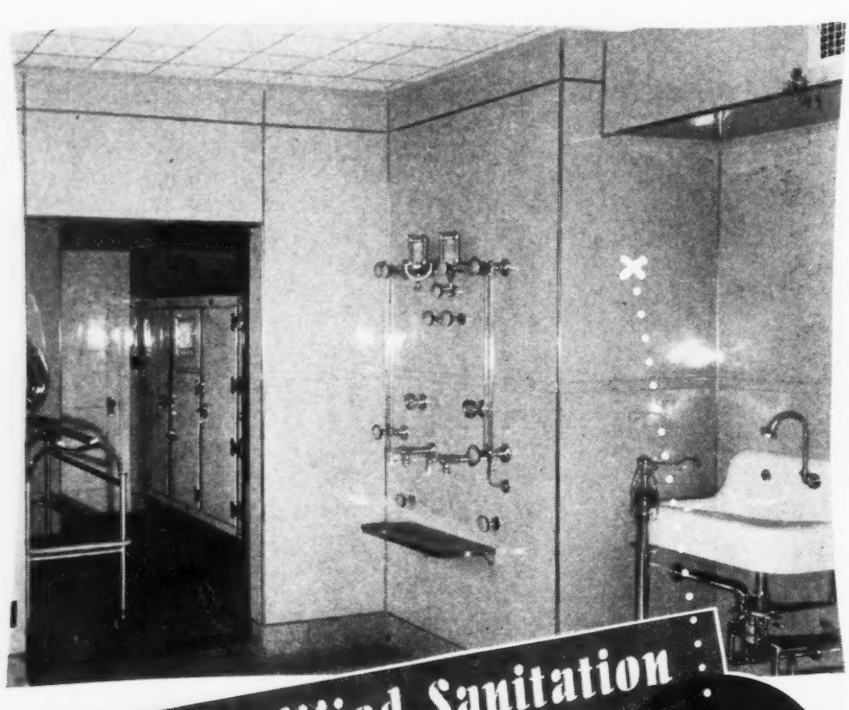
"These costs of medical education must be met if it is to be maintained at the level necessary to ensure proper medical care," the statement continued. "In private institutions they can be met only by large increases in endowment funds, or long term gifts or both.

"Over the last fifteen years private support of medical education has not been regularly maintained. Three or four medical schools came perilously near to closing during that period. Many medical schools were forced to abolish certain teaching positions, to reduce teachers' salaries and important medical services, to restrict promising research and to make heavy demands upon the time and energy of doctors, nurses and hospital staff and to forego normal growth and improvement.

"Unless existing conditions are quickly changed, medical education will decline in quality and medical research will falter.

"We believe that if this situation is clearly understood by our fellow citizens, they will rally to the support of medical education. Through private support American medical schools have set a standard for the world. Private support should not now abandon them through ignorance of the facts, temporary uncertainties or absence of mind. We warn our fellow citizens that without their prompt and generous aid our medical schools, through their graduates, cannot be expected to safeguard the future health of American citizens and their children."

The statement was signed by presidents of the following institutions: University of California, Columbia, Cornell, Duke, Harvard, State University of Iowa, Johns Hopkins, Michigan, Minnesota, New York University, Northwestern, University of Pennsylvania, University of Rochester, Stanford, Tulane, Vanderbilt, Washington University, Western Reserve and Yale.



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I.C.N. in First Postwar Congress

The International Council of Nurses will hold its first postwar quadrennial congress in Atlantic City, N. J., May 11 to 16. Effie J. Taylor is the council's president; Anna Schwarzenberg, executive secretary.

Is upkeep getting you down? Then why not reduce your *underfoot* overhead and brighten your own "outlook" as well as that of your cafeteria and other rooms? A Kentile floor will turn the trick in a jiffy!

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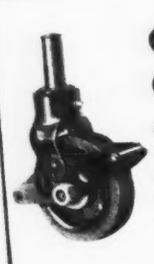

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Rhode Island, Blue Cross Leader, Has Best Year

Rhode Island Blue Cross completed the most successful year in its history, Kenneth D. MacColl, president, said in his report at the annual meeting held in March. Enrollment now totals over 463,000 subscribers, representing 66 per cent of the state's eligible population and placing the Rhode Island Blue Cross in first place among all statewide plans in the country, Mr. MacColl said.

Last year represented the largest growth in membership, with the addition of more than 123,000 new subscribers, an increase of 38.1 per cent, he added.

In view of rapidly rising hospital costs, hospitals are expected to request Blue Cross to raise its rates to subscribers so that "hospitals may more adequately be reimbursed for care and treatment rendered to Blue Cross subscribers," the report indicated. Payments now cover only about 95 per cent of the charges billed by hospitals.

In commenting on the negotiations with the Rhode Island Medical Society for operation of a prepaid surgical plan, which fell through recently, Mr. MacColl said that "Blue Cross still stands ready to cooperate with the Rhode Island Medical Society, but we feel that it is a matter of principle that we must offer to our subscribers a free choice of physician, a stand which is supported by subscribers, labor organizations and employers, as evidenced by many letters and telephone calls."

Mr. MacColl reviewed the history of the discussion between the two organizations and stated that Blue Cross had made a counter proposal which was approved by the council of the Rhode Island Medical Society and referred to the house of delegates for action. Unfortunately, the house of delegates rejected this proposal.

Sputum Cups Available at Bargain Prices

WASHINGTON, D. C.—Close to 2,000,000 packages of 100 sputum cups are being sold at bargain prices, W.A.A. announced March 4. Hospitals, tuberculosis sanatoriums and convalescent homes may now acquire stocks at virtually their own prices.

The cups are made of waxed paper and are packed flat. After folding, the average size is 2½ inches in each dimension; some are 2¾ inches square by 2¼ inches high with lids 3¼ inches square. Most cups have a flap cover or lid and all are types usable in hospitals and sanatoriums.

Minimum lots of such size that small customers may participate in the sale will be established.

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Graduate Program in Hospital Administration at University of Iowa

The University of Iowa has announced the establishment of a program in hospital administration which will be offered under the direction of Dr. Carlyle Jacobsen, dean of the graduate college, and Gerhard Hartman, superintendent of University Hospitals and professor of hospital administration.

The program is to be divided into two phases, an administrative internship which will last for a period ranging from six to eighteen months, and an administrative residency extending over another period of six to eighteen months. Progression from the first to the second phase will be determined on the basis of each individual's qualifications and achievements.

The character of the in-service training portion of the program will vary and may include (1) working with the administrator, department heads and other departmental employes, (2) working on projects assigned by the superintendent, in the solution of which the intern will work in a specific department, consult with the department heads and others, and then report his findings. Increasing administrative responsibility will be given the administrative intern or resident as he develops.

Throughout the intern and resident periods the candidates will attend the various hospital conferences and meetings and, in addition, periodic conferences with department heads will be held.

Upon entering the internship period candidates will be enrolled in the graduate college of the University of Iowa, which, in addition to providing cultural and social advantages, will give candidates the opportunity of enrolling in university classes which appear necessary to fill educational gaps in the candidate's background. The academic portion of the program will be varied to suit the needs of the individual. Some students will be candidates for degrees and others will be taken into the program to fulfill internship requirements of other hospital administration programs. The degrees offered will be the Master's or Doctor's in Science in Hospital Administration.

In addition to the in-service training program offered at the University of Iowa Hospitals, in-service training will be given at community hospitals in the state. It is felt that this affiliation with other hospitals will be of material benefit, as the university hospitals are unique rather than typical.

Since internship training for hospital administration is still in its experimental stage, the exact length and full content of the program are being developed according to a flexible educational pattern.

The first administrative intern in the program, Howard F. Cook, has already undertaken his studies.

Persons in the hospital field who have demonstrated unusual achievement and graduates of the academic portion of the university courses in hospital administration at Chicago, Northwestern, Columbia, Washington, St. Louis and the University of Minnesota are eligible for admission to the program at the University of Iowa.

New Navy Nurse Corps Reserves

WASHINGTON, D. C.—Reorganization by the Bureau of Medicine and Surgery of the Nurse Corps, U. S. Naval Reserve, was announced March 3 by R. Adm. Clifford A. Swanson, surgeon general. The new program looks toward the establishment of the Nurse Corps Reserve on a firm basis. The Bureau of Medicine and Surgery is endeavoring to contact all nurses who served during the war and are now on inactive status. Nurses who have not received the new questionnaire are urged to get in touch with the superintendent of the Nurse Corps, Bureau of Medicine and Surgery, Navy Department, as soon as possible.

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Production Outlook for 1947 Appears Fairly Favorable

By EVA ADAMS CROSS

WASHINGTON, D. C.—A considerable percentage increase in the construction of hospital facilities in 1947 was predicted by Maj. Gen. Philip B. Fleming, administrator of the Office of Temporary Controls, in a special report "The Production Outlook for 1947" released recently.

Good news for hospitals, too, is the fact that the year's output of consumer durable goods is expected to exceed that of 1940-41, highest in the history. Leading increases will be in mechanical refrigerators and electric irons, with washing machines close behind. Production of mechanical refrigerators will surpass the prewar rate of 309,000 a month.

Supplies of building materials are expected to improve considerably in 1947, though the report warns that it is too early to say that no difficulties will be encountered. Clay and masonry products (brick, tile, cement block) are expected to be in adeqaute or even ample supply. Some easement in the millwork situation is anticipated. Hardwood flooring will probably remain tight.

Although gypsum lath is expected to be a problem for some time, general betterment of the building board picture is looked for. Roofing material will be in balanced supply and considerable improvement in plumbing fixtures is forecast. Supplies of heating equipment are already much improved and should offer no obstacles.

Considerable improvement is indicated in the production of electrical equipment and builders' hardware, and substantial gains are expected in cast-iron soil pipe, the most critical item in construction at the present time .

Production of exterior paint this year should be around 48,000,000 gallons, 7,000,000 or 8,000,000 gallons short of expected demand. Interior paint supplies will probably come close to meeting demand, since they require smaller quantities of linseed oil and pigment.

Continuing shortages in tin, lead and aluminum are in the cards.

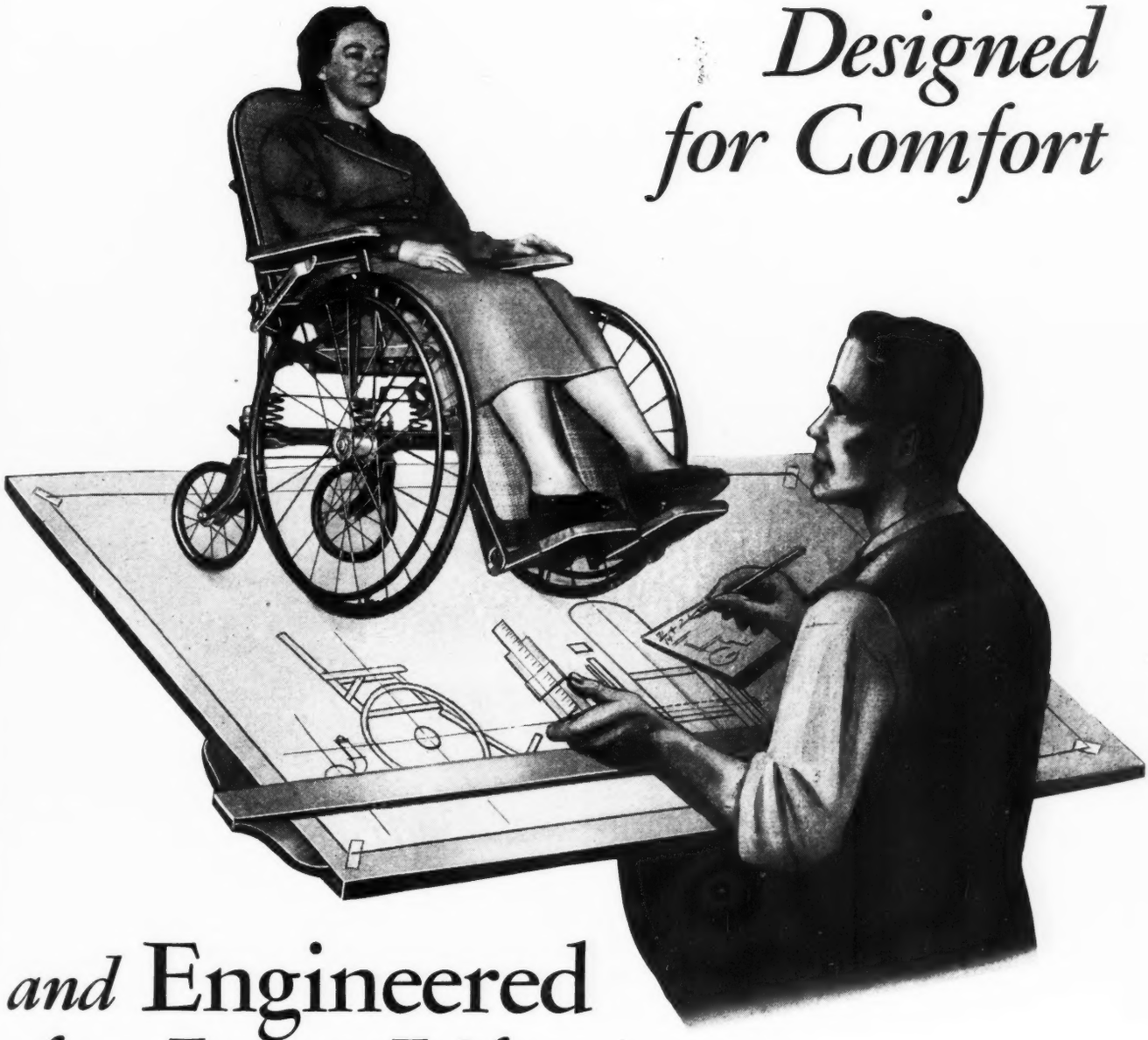
Some easing in the pulp, paper and paperboard situations may be expected, but not before the latter half of the year.

General prospect for textiles and apparel is for continued improvement in production, with approximate balance of supply and demand by year's end.

Practical Nurses to Meet

The sixth annual conference of the National Association for Practical Nurse Education will be held on May 5 and 6, at the headquarters of the Visiting Nurse Service of New York, 262 Madison Avenue.

Designed for Comfort



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In addition to making more than 50 distinct wheel chair designs, Gendron also manufactures wheel stretchers, examination tables, commodes and back rests.

Gendron Wheel Company

PERRYSBURG, OHIO

Tri-State Assembly to Include Forums, Trustee Institute

Administrators, medical staff members, nurses, dietitians and other hospital personnel in the states of Illinois, Indiana, Michigan and Wisconsin will meet at the Palmer House in Chicago May 5, 6 and 7 for the 17th annual Tri-State Hospital Assembly. Some 60 organizations in the four states will be represented, according to Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, who is general chairman.

Meetings for all groups and sections will include three morning general assemblies; a forum on "The Modern Hospital—A Complicated but Synchronized Entity" on Monday evening, May 5, at 7:30; a banquet on Tuesday evening at 7 o'clock, and an "Information Please" session from 3:45 to 5:45 on Wednesday afternoon.

The 31 sections will hold a total of 47 meetings on the three afternoons. Among these will be a trustees' institute which will meet every afternoon under the chairmanship of Allan M. Williams of Ionia, Mich., trustee, Ionia County Memorial Hospital.

More than 100 firms that manufacture or distribute hospital equipment and supplies will be represented in the technical exhibit.

The speaker who will open the forum on Monday evening, May 5, will be John H. Hayes of New York, superintendent of Lenox Hill Hospital and president of the American Hospital Association. The banquet speaker on Tuesday evening will be Dr. Joseph C. Doane of Philadelphia, medical director of the Jewish Hospital, who will discuss "How Hospitals Can Help to Achieve the Objectives of Preventive Medicine." Both the forum and the banquet will be held in the grand ballroom of the hotel, as will the three morning general assemblies and the "Information Please" session.

The Monday morning general assembly will have as its theme, "Adjusting Hospital Service to Medical Progress." The Tuesday morning general assembly theme will be "Developing Management Technics and Controls," and the Wednesday morning general assembly theme will be "The Long View in Hospital Planning."

On the first day, a luncheon will be sponsored by the American College of Hospital Administrators for administrators and others who are interested in attendance.

Inaugurate Specialty Training Program for Negro Physicians

A specialty training program for Negro physicians will be staffed by white doctors at Provident Hospital, Chicago, Negro institution, under the sponsorship of the Provident Medical Associates, Dr. M. O. Bousfield, technical director of the associates, announced March 27. The program, which is financed by philanthropic contributions to the sponsoring organization, will provide scholarship funds for young Negro doctors seeking specialty training in a move that has been described as "an unprecedented assault on the color line in medicine."

"There have been too few certified Negro doctors for specialty teaching and too few hospitals to teach in," Dr. Bousfield stated, pointing out the need for Negro specialists to staff hospitals throughout the country. "This project is an effort to develop specialists who will in turn be able to teach others. This cooperation between white and colored doctors is another demonstration that science has no bounds of color and creed," Dr. Bousfield concluded.

The associates will provide from 10 to 15 scholarships a year, it was explained. Members of the sponsoring group include leading medical school officials and practicing physicians in the Chicago area.

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*"Since installing your payroll system two years ago," writes Our Lady of Victory's Care, Lackawanna, New York, "we have found that it does everything you promised. For one thing, it has resulted in the saving of clerical hours, which is important. Another advantage is the ease with which we are able to prepare governmental reports." Besides, adds the letter, "our payroll records now are very helpful to us in analyzing the activities and expense of our various departments."

These and other benefits, characteristic of the Todd Payroll System installed at this well-known hospital and orphanage, are typical. Todd Payroll Systems eliminate as much as 50% of payroll preparation time—increasing efficiency, decreasing costs! There is no costly outlay for equipment and, with a Todd Payroll System, any clerk can prepare the payroll sheet, individual earnings record, and employee's statement of earnings in a single operation. Want to know how a Todd System might help you? Just mail in the coupon and we'll see that you get complete information without obligation or expense.

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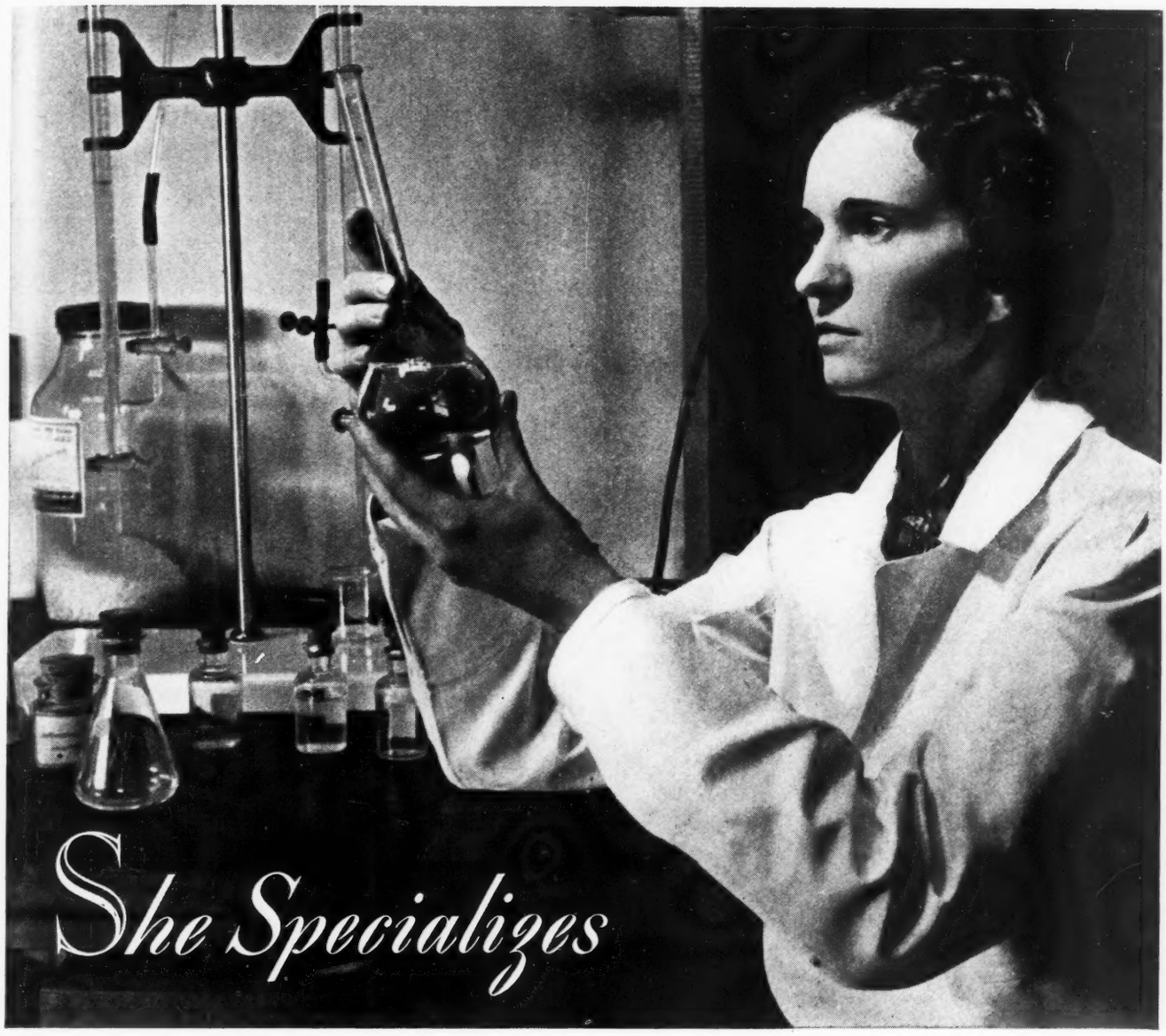
100 Accountants Attend A.H.A.-U.H.F. Institute

A five day institute sponsored by the American Hospital Association and the United Hospital Fund of New York drew more than 100 hospital accountants from 24 states to New York City the week of March 24. Charles G. Roswell, hospital accountant consultant of the United Hospital Fund, was director of the institute which included lectures and discussions covering current problems and procedures of hospital accounting practice.

Speakers included John H. Hayes, A.H.A. president; William J. Donnelly, Greenwich, Conn.; James W. Stephan, University of Minnesota; Dr. Claude W. Munger, St. Luke's Hospital, New York; Dr. Edwin L. Crosby, Johns Hopkins Hospital, Baltimore, and William H. Markey Jr., A.H.A. accounting specialist.

COMING MEETINGS

ALBERTA HOSPITAL ASSOCIATION, Edmonton, Alta, Oct. 20-26.
AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Hotel Commodore, New York City, Sept. 8-12.
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, St. Louis, Sept. 22-25.
AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Hotel Jefferson, St. Louis, Sept. 20-22.
AMERICAN COLLEGE OF SURGEONS, Sectional Meetings: Vancouver, B. C., April 21-22; Winnipeg, Man., April 28-29. Clinical Congress, Waldorf-Astoria Hotel, New York City, Sept. 8-12.
AMERICAN DIETETIC ASSOCIATION, Philadelphia, Oct. 13-15.
AMERICAN HOSPITAL ASSOCIATION, Hotel Jefferson St. Louis, Sept. 22-25.
AMERICAN MEDICAL ASSOCIATION, Atlantic City, June 9-13.
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Hotel Del Coronado, San Diego, Calif., Oct. 3-Nov. 7.
AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Sept. 19-21.
AMERICAN PUBLIC HEALTH ASSOCIATION, Atlantic City, N. J., Oct. 6-10.
ARKANSAS HOSPITAL ASSOCIATION, Little Rock, May 15-16.
ASSOCIATION OF BAPTIST HOMES AND HOSPITALS, Atlantic City, N. J., May 19.
ASSOCIATION OF WESTERN HOSPITALS, Seattle, Wash., May 12-15.
CANADIAN HOSPITAL COUNCIL, Winnipeg, Man., Oct. 16-18.
CATHOLIC HOSPITAL ASSOCIATION, Mechanics Hall, Boston, June 16-20.
FLORIDA HOSPITAL ASSOCIATION, Biloxi, Miss., April 10-12.
HOSPITAL ASSOCIATION OF NEW YORK STATE, Buffalo, May 21-23.
ILLINOIS HOSPITAL ASSOCIATION, Palmer House, Chicago, May 5-7.
INDIANA HOSPITAL ASSOCIATION, Palmer House, Chicago, May 5.
IOWA HOSPITAL ASSOCIATION, Des Moines, April 21-23.
MARITIME HOSPITAL ASSOCIATION, Algonquin Hotel, St. Andrew's, N. B., June 4-7.
MICHIGAN HOSPITAL ASSOCIATION, Palmer House, Chicago, May 5-7.
MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 23-25.
NEW JERSEY HOSPITAL ASSOCIATION, Dennis Hotel, Atlantic City, May 15-17.
NEW MEXICO HOSPITAL ASSOCIATION, Hotel Clovis, Clovis, N. M., May 23-24.
OREGON ASSOCIATION OF HOSPITALS, Seattle, Wash., May 12-15.
PENNSYLVANIA HOSPITAL ASSOCIATION, Pittsburgh, April 23-25.
TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 5-7.
WASHINGTON STATE HOSPITAL ASSOCIATION, Seattle, May 11-15.



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Wisconsin Blue Cross Is Now Writing Individual Contracts

Wisconsin Blue Cross hospital protection is now available for persons on an individual nongroup basis, according to an announcement by L. R. Wheeler, executive secretary of Associated Hospital Service, Inc., Milwaukee.

Announcement of the new protection was made in answer to public demand for coverage of persons not employed in groups, Mr. Wheeler said. The new individual contract is quite similar to that being offered in groups, since it includes 100 per cent coverage on most incidental costs of hospitalization during a twenty-one day hospital stay.

The Blue Cross individual contract will extend the opportunity of enrolling in a nonprofit prepayment plan to the self employed, unemployed and persons who are employed where there are groups of less than five. People who are under 65 years of age, in general good health and who are not eligible for enrollment on a group basis may make application for this protection.

Under the new contract, individuals may enroll on a quarterly or annual basis, by making payments in advance of $1 a month for single persons and $2.25 for families.

Mr. Wheeler also announced that Associated Hospital Service has found it necessary to take over larger quarters for its operation. The Blue Cross agency will move into a building at 826 North Plankington Avenue, Milwaukee, as soon as remodeling is completed. Blue Cross will utilize six of the seven floors in its new location and the other will be reserved for further expansion, according to Mr. Wheeler.

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Smooth as Butter . . . Appetizing as Caramel—There is enough fresh creamery butter in every pint of Buttered Caramel Jullicum to increase the butterfat content of milk by 15%, giving the nourishment of rich, whole milk, at no extra cost! And, as the appetizing, aromatic flavor of caramel is freed of all harshness by the smooth richness of the butter, so the firm, fine texture—characteristic of all Jullicum desserts—is correspondingly improved.

Top-Quality Nourishment . . . No Extra Cost—Jullicum desserts provide the matchless food values of milk in its most appetizing, easily digested form. And since Jullicum is liquid rennet, it is utterly simple to use, requires no preparation, and blends quickly with milk to create delicious, firm, quick-setting desserts . . . with enough flavors for each day of the week, plus one extra, to dodge monotony . . . Yet Jullicum is *economical*: a pint will flavor and rennetize 128 full, four-ounce desserts at a cost of only about one cent per serving!

SAM'L B. KIRK, 261 South Third St., Philadelphia 6, Pa.

Ask for a Sample, or send your order on this coupon:

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GENTLEMEN: ☐Please send me, without charge ..... *Jullicum* samples, flavors as indicated.

☐Please ship at once ..... pints of *Jullicum* liquid rennet in these flavors: ..... Buttered Caramel ..... Almond ..... Chocolate ..... Vanilla ..... Coffee ..... Orange ..... Lemon ..... Raspberry, at $1.50 postpaid, or $8 per case of 6 (east of the Mississippi) express prepaid.

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New York Group Backs Pay Rise and 40 Hour Work Week for Nurses

At a meeting last month, the Greater New York Hospital Association supported the request of New York City nurses for increased pay and shorter hours. The association approved a basic annual wage of $2400 and a 40 hour week for staff duty nurses and $10 a day, plus meals, for an eight hour private duty nurse.

The association recommended that voluntary hospitals in greater New York try to raise standards accordingly as promptly as possible.

Newman M. Biller, secretary of the association, stated that the action was taken not only for the welfare of nurses now working in hospitals but also for the purpose of attracting nurses who have left the profession back into hospital work and stimulating young women into an interest in nursing.

At the same time, it was recommended that the association cooperate with the private duty nurses acting as independent contractors and afford them reasonable opportunity to establish the following rates for private duty nursing in the member hospitals: $10 plus meals for eight hours of duty with an additional dollar to be charged in certain instances. Twelve hour duty is not approved or endorsed but should it be necessary for a nurse to work that length of time the rate is to be $15 plus meals.

Finally, the association approved the recommendation of its personnel relations committee to enter into a continuing and joint relationship of cooperation with local districts of the New York State Nurses' Association in order to arrive at mutually satisfactory solutions of problems arising in connection with employment conditions for nurses engaged in the voluntary hospitals of greater New York.

Hospital Changes Name

The board of trustees of Homeopathic Hospital of Rhode Island, Providence, has announced that the name has been changed to Roger Williams General Hospital.

Sunway BEVERAGE BASE

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available in Orange, Lemon and Lime Flavors

12-Oz. Can Makes 4 Gallons of Beverage

This can when packed contained 7.69 GMS. of VITAMIN C (Ascorbic Acid) and .0649 GMS. VITAMIN B_1 (Thiamine Hydrochloride).

The FINISHED BEVERAGE, made according to directions on label, will contain 120 MGS. VITAMIN C, 1.0 MG. of VITAMIN B_1 and 116.3 CALORIES, TO EACH 8-OZ. GLASS.

This provides 100 and 400 per cent respectively of the adult minimum daily requirements for VITAMINS B_1 and C.

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These delicious new dehydrated fruit juice flavors are developed by a new and exclusive process and are ***Easy to Prepare*** — just add water and sweeten.

So Economical to Use—One 12-ounce can of SUNWAY BEVERAGE BASE makes 4-gallons of true fruit beverage, and costs only $1.50. Cost of 8-oz. glass of "Sunway", including sugar is approximately 2½ cents.

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Highlines were down everywhere, communities isolated, communications disrupted when a severe blizzard swept the Upper Midwest on November 11th, 1941.

The storm cut power to the Nagel Hospital in Waconia, Minnesota . . . oil burners and lights went off. With makeshift lighting and small kerosene stoves for heat, the hospital struggled through until power was restored.

Dr. Nagel, founder and head of the hospital was determined it should never happen again. He installed an Onan 3000-watt electric plant, supplying the same type of A.C. power as the highline, for use in emergencies. Several times since then highline power has failed and the Onan Plant has supplied electricity for lights, the oil burner heating system and other uses.

An Onan Electric Plant guarantees uninterrupted electrical service. It is low-cost insurance for hospitals and other institutions where dependable power is essential.

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ONAN ELECTRIC PLANTS are built in many sizes and models. A.C.—350 to 35,000 watts in standard voltages and frequencies; D.C.—600 to 10,000 watts, 115 and 230 volts. Battery chargers—500 to 3,500 watts, 6 to 115 volts.

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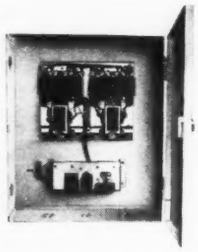

When power fails the control panel automatically starts the Onan Electric Plant and switches its power to branch circuits. When power is restored, the plant stops automatically.

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A.H.A. Sponsors Personnel Institute in Houston, Tex.

Improved hospital personnel administration will be the goal of the Personnel Institute to be conducted by the American Hospital Association at the University of Houston, Houston, Tex., May 26 to 30.

During the five day institute, specialists in hospital personnel administration and faculty members of the University of Houston will conduct lectures, seminars and informal discussions on various problems in developing sound personnel administration in all hospitals, regardless of size, according to Mrs. Ann Saunders, personnel consultant, American Hospital Association, who will be in charge of the institute.

Topics for lectures will include principles of personnel philosophy, development of a master plan for personnel programs, motivation of the worker, job analysis and evaluation, worker evaluation, ways to increase efficiency, function of bargaining groups without the right to strike, improvement in working conditions, therapeutic relief for employe complaints. Small seminar groups will discuss fundamental functions and policies in developing personnel programs.

Sponsors of the institute include the Texas Hospital Association, the Houston Area Hospital Council and University of Houston. Registration, limited to 75 persons, is open to personal members of the American Hospital Association, administrators, personnel officers or persons named by the administrator of association member hospitals.

President Urges Joining World Health Organization

WASHINGTON, D. C.—President Truman urged membership in the World Health Organization in a message delivered to both Houses of Congress March 21. A memorandum from the Secretary of State on this subject and a suggested joint resolution were included with the message and referred to the committee on foreign relations.

"I have been impressed by the spirit of international good will and community of purpose which have characterized the development of the constitution of this organization. I am sure that it will make a substantial contribution to the improvement of world health conditions through the years," read the President's message.

Mr. Truman's message concluded by pointing out the urgency of the United States' becoming a member of the W.H.O. as soon as possible. The President asked the early consideration of Congress of the suggested resolution.

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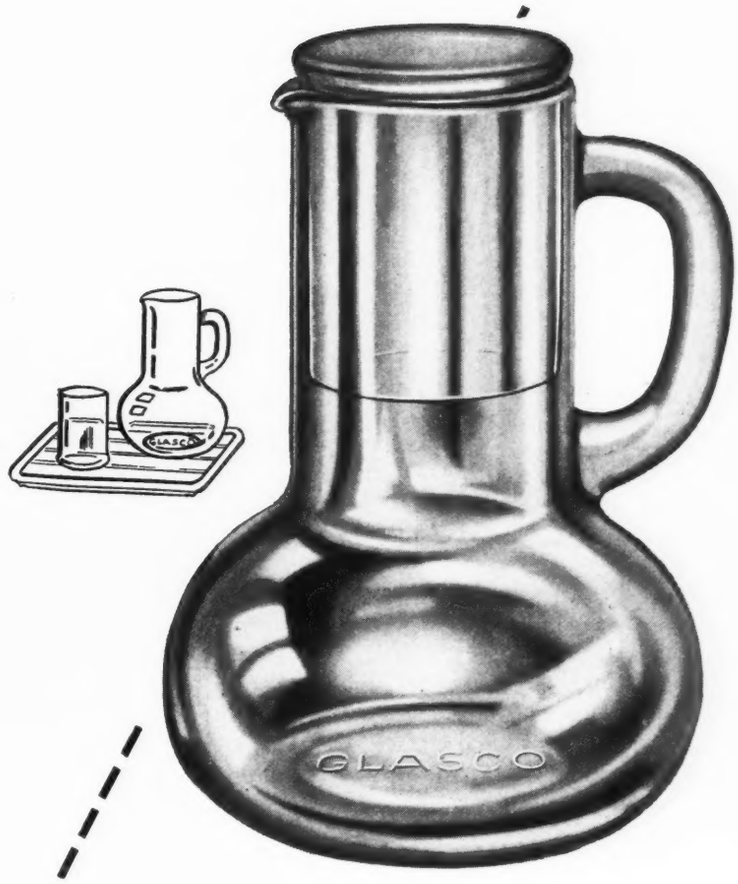

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Per DOZEN	$10.30	$6.00	$4.30
3 DOZEN LOTS Per DOZEN	9.35	5.40	3.95
6 DOZEN LOTS Per DOZEN	8.30	4.80	3.50
GROSS LOTS Per DOZEN	7.60	4.50	3.10

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District of Columbia Attacks Problem of Nurse Shortage

Gallinger Municipal Hospital, Washington, D. C., will shortly accept both white and colored vocational high school students for clinical training in practical nursing. This significant move represents the culmination of many months' effort, compromise and long range planning on the part of numerous professional groups to help hospitals meet the dire need for nursing help.

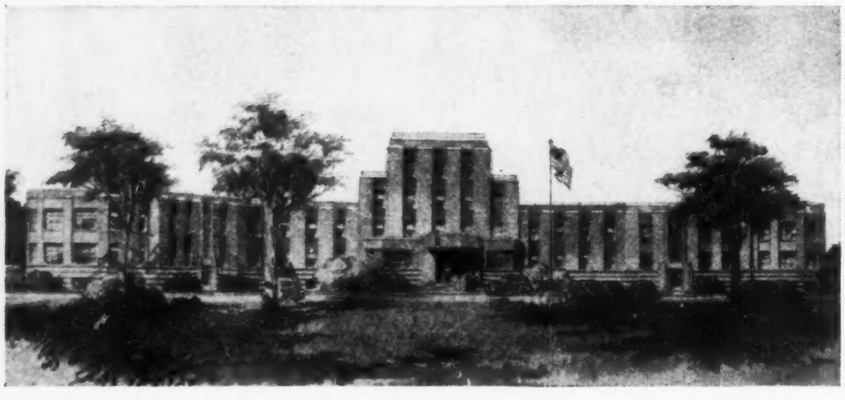
The approval of the D. C. nurse examining board of Gallinger's operating a school for practical nurses as well as one for professional nurses reverses the former policy of the board. Beatrice Ritter, nursing director of Gallinger, and Edith Beattie, executive secretary of the D. C. Graduate Nurses' Association, both urge caution and careful planning in such practice.

These two graduate nurses see eye-to-eye with the national professional nursing groups that "only in occasional instances where there is a strong substantial control should both a school for the preparation of professional nurses and a school for practical nurses be operated under the same auspices."

In the meantime, sparked by the American College of Surgeons, some District of Columbia hospitals have been considering the training of auxiliary nurses. Those training professional nurses, however, have been cautious in initiating such courses so long as the District examining board held to its former policy. Doctors' Hospital, not thus restricted, last year introduced a fairly ambitious program for the training of practical nurses. A new class of 35 applicants recently began training.

Special duty nurses in Washington, registered with the Graduate Nurses' Association, raised their fees April 1 from $1 to $1.25 an hour. The association's registry will require $10 for the normal eight hour day, and $15 for a 12 hour day. Other graduate nurses in the city, not affiliated with the association registry, have been charging the higher fees for some time, it is said.

John Smith's Hospital



John Smith—and his friends and relatives in Cambridge and Guernsey County, Ohio—have just financed the Guernsey Memorial Hospital in the biggest fundraising campaign in the community's history.

Few thought that the goal of $350,000 could be attained.

But John and his public spirited and generous fellow citizens raised over $392,000!

No gift was over $15,000. Most of the money was contributed by persons of moderate means who made a real sacrifice to support their new hospital.

In its over-the-top editorial, the Cambridge "Jeffersonian" concluded that "the drive served to emphasize the importance of engaging persons who make a business of campaigning to direct any extensive money-raising effort."

Ketchum, Inc. directed this successful hospital campaign.

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FRANK L. SCOTT, JR., *Vice President*

Member American Association of Fund Raising Counsel

300 Attend New York Academy Centennial

Physicians must devote a larger share of their attention to the health of all the people, Dr. Dean A. Clark, medical director of the Health Insurance Plan of Greater New York, told an institute on social medicine held in connection with the centennial celebration of the New York Academy of Medicine in New York last month.

"If there is any hope that the patient will some day realize his full responsibility in health, the doctor must show the way," Dr. Clark declared. "But he can do this only if he can offer the full personal, emotional and social, as well as medical, understanding that his patient requires and, furthermore, only if the patient has full access to his services."

The institute was attended by more than 300 medical scientists from the United States and several foreign countries.

Dr. Basil C. MacLean of Strong Memorial Hospital, Rochester, N. Y., said that hospital buildings must be planned and designed better in the future than they have been in the past. "It is time institutions for the care of the sick got away from the stable-like accommodations which we identify as semiprivate," Dr. MacLean declared.

Opens Psychiatric Unit

A newly renovated section for patients with psychiatric disorders, who do not require treatment in a hospital for the mentally ill, has been opened by Mount Sinai Hospital, New York City. At the same time, expanded outpatient facilities for ambulatory cases of this type have been provided.

GOODALL *Blended-for-Performance* FABRICS

make maintenance easier—

● Goodall ***Blending-for-Performance*** creates special fabrics and even special designs for hospital use. Draperies, and upholstery made by Goodall blending techniques shed dirt better and clean more easily. Blending also creates fabrics for bedspreads that are soft but resilient . . . do not muss or crease. Their brighter colors *stay* brighter . . . in gay, interesting designs that are constant sources of cheer for the convalescent.

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Subsidiary of Goodall-Sanford, Inc.
● THE FINEST NAME IN FABRICS

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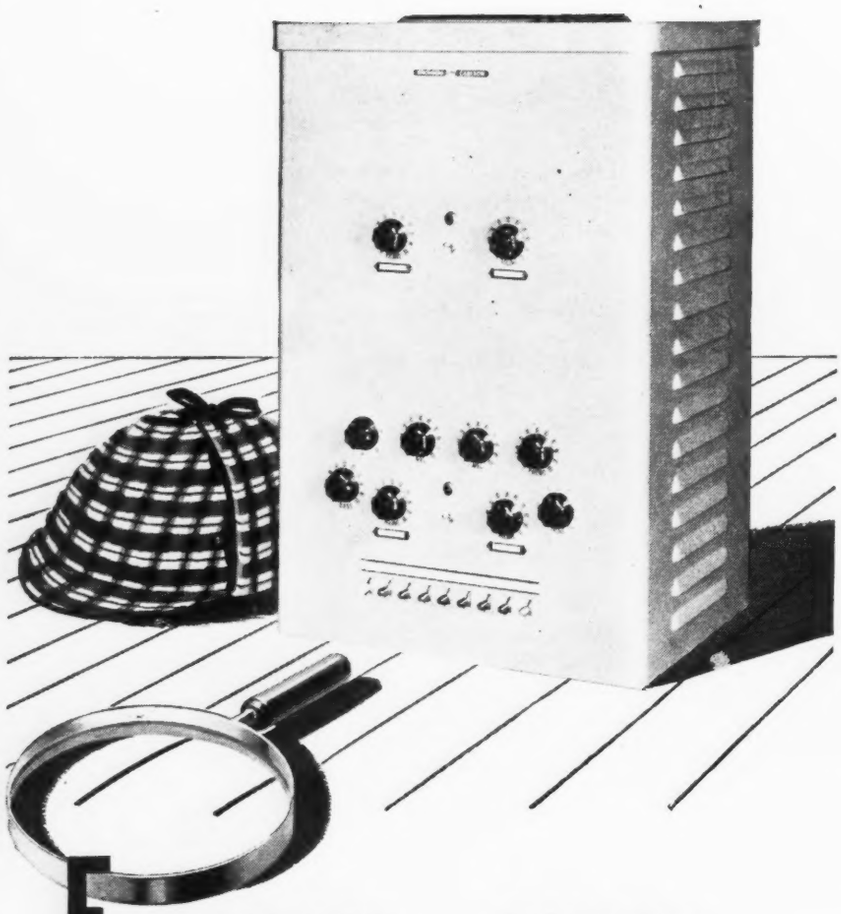


ELEMENTARY . . . DOCTOR!

Finding the right person, at the right time—fast—is really quite simple. The solution, as you've probably guessed, is a new modern Stromberg-Carlson sound system.

You know the efficiency of such a system for paging, the therapeutic value of controlled music and, its many other uses. *But don't think it need be costly!*

The Model 725 Hospital Sound System (illustrated above) is a Stromberg-Carlson pre-engineered unit designed especially for medium sized installations. Controls for paging microphone, additional microphone, record player, special service telephone line, four speaker groups and all-call are contained in its small, compact cabinet. It is economical to install, easy to operate. It is engineered and built with the same skills which distinguish the famous Stromberg-Carlson radios and telephone equipment.

See it at your local Stromberg-Carlson sound system distributor today (listed in your phone book). Or write for free booklet, "Sound Systems for Hospitals." Address: Stromberg-Carlson Co., Sound Equipment Division, Dept. M4, 100 Carlson Road, Rochester 3, New York.

STROMBERG-CARLSON

NATURAL-VOICE SOUND SYSTEMS

W.A.A. Announces 100 Customer Service Centers for Buyers

WASHINGTON, D. C.—The network of more than 100 customer service outlets, announced March 6 by W.A.A., established in strategic cities over the country, sounds like good news to prospective buyers in the hospital field.

A complete file in each center on all offerings in all regions will permit the hospital buyer to go to one place to find property located in any part of the United States. This will eliminate the expense of travel to distant cities or of making long distance calls to learn where merchandise is available.

Forty-five customer service centers are already open and in full operation; 46 others are in partial operation. Geared to bring better service to customers, the centers will maintain current information about all planned or advertised sales, giving the buyer the complete national sales picture. Such a program will greatly facilitate priority sales. Personnel at the centers will be prepared to reply to all inquiries about sales, will handle priority information and priority applications.

Hundreds of property samples and photographic blow-ups will be on display. Inventories in each region will be checked weekly and sent to each center. These will serve as valuable tip sheets to prospective buyers.

Centers are established in downtown business districts of large cities. Plans are under way to establish subsidiary centers and to send out representatives from large centers to reach less populated regions and to contact all buyers, large and small.

C. G. Salisbury Heads Arizona Association

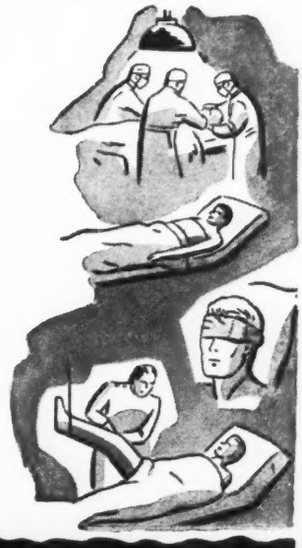
Dr. C. G. Salisbury, superintendent of Sage Memorial Hospital, Ganado, was named president of the Arizona Hospital Association at the annual convention in Phoenix March 7 and 8. Dr. Salisbury was also made delegate to the American Hospital Association.

Features of the meeting were an address on the physicians' responsibility to hospitals by Dr. Robert S. Flinn; a description of the American Hospital Association's national program by Kenneth Williamson, assistant A.H.A. director, and a round table discussion conducted by Mr. Williamson and Ritz Heerman of Los Angeles on the subject of Blue Cross payments to hospitals.

Other officers named by the association were vice president, Mother Eileen, superintendent, St. Mary's Hospital, Tucson; secretary-treasurer, Guy M. Hanner, Good Samaritan Hospital, Phoenix.

Quick and Simple to Use STOCKINETTE... Practical for Hospital Needs

ADLER ORTHOPEDIC STOCKINETTE



Because it's amazingly simple to use, Adler Orthopedic Stockinette is practical for innumerable hospital needs. Hospital purchasing agents have ordered and re-ordered Stockinette because of its economy. Perfect under plaster casts, over dressings, and as skin protection during operations; valuable in the manufacture of orthopedic appliances, and as wristlets on surgeons' gowns. Its uses are as varied as the user's ingenuity. Made of long staple cotton, carefully fabricated to give correct strength and elasticity—comes in 50-yard rolls. At your dealer's by the pound or yard.

MADE BY **THE ADLER COMPANY** CINCINNATI 14, OHIO

Minneapolis to Give X-Ray Tests to Entire Adult Population

For the first time in history a city of more than 100,000 population, Minneapolis, is endeavoring to give free chest x-ray examinations to its entire adult population. Starting on May 5, the job is expected to take three months.

The purpose of the survey is to locate unsuspected cases of tuberculosis, cancer in the chest cavity and heart conditions, as well as 60-odd other diseases which may show up.

Three mobile x-ray units and seven portable units will be in operation throughout the city during the survey. The project is being sponsored by the Hennepin County Medical Society and the Hennepin County Tuberculosis Association. Directing this gigantic health venture is the Minneapolis City Health Department, with the cooperation of the United States Public Health Service.

Each person will be offered an opportunity to have a 70 millimeter chest x-ray examination in one of the modern units.

In suspected cases the individuals will be asked to go to the public health center for a second x-ray test.

If the need for further diagnosis is confirmed, the individual and his doctor will be informed. From this point, the followup will be on the normal patient-doctor basis, with this exception: persons disclosed to have tuberculosis will be reported to the city commissioner of health.

Public health nurses will be active workers in the survey. They will be prepared to answer any questions an individual might ask, as well as to give advice, counsel and direction.

House Votes Permanent Nurse Corps for Army, Navy

WASHINGTON, D. C.—The House of Representatives voted March 13 to establish a permanent Nurse Corps of the army and the navy and to establish a Women's Medical Specialist Corps in the army.

The measure gives permanent commissioned status to nurses of both services and to the women of the Medical Specialist Corps of the army. Pay, leave, subsistence and rental allowances and other benefits would be similar under the bill to male officers' benefits. Retirement benefits are identical. Retirement age is set at a lower level.

Originally, bills were submitted separately, one for the Army Nurse Corps and one for the Navy Nurse Corps. The surgeons general of the army and of the navy, Col. Blanchfield of the Army Nurse Corps, and Capt. DeWitt of the Navy Nurse Corps, and others concerned met in conferences, however, and worked out a composite bill which was drafted and proposed by Rep. Margaret Chase Smith.

"It is not a perfect bill," said Capt. DeWitt, "but it fills the need for the present."

Dr. M. H. Collier Heads Sanatorium Group

Dr. Martin H. Collier, superintendent of Camden County Tuberculosis Hospital, Camden, N. J., was elected chairman of the Tuberculosis Sanatorium Conference of Metropolitan New York at the joint annual meeting of the conference with the New York Tuberculosis and Health Association last month.

Dr. William G. Childress, physician-in-charge of the tuberculosis division, Grasslands Hospital, Vaihalla, N. Y., was elected vice chairman. G. Donald Buckner, secretary of the tuberculosis division of the New York Tuberculosis and Health Association, was reelected secretary of the conference and G. J. Drolet, statistician of the association, was reelected consulting statistician of the conference.

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For assurance of quality, specify windows of Alcoa Aluminum. Leading window manufacturers produce them in a variety of standard and special types and sizes. For a list of these manufacturers, write to:

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IN EVERY COMMERCIAL FORM

Streptomycin Allocations Are on the Increase

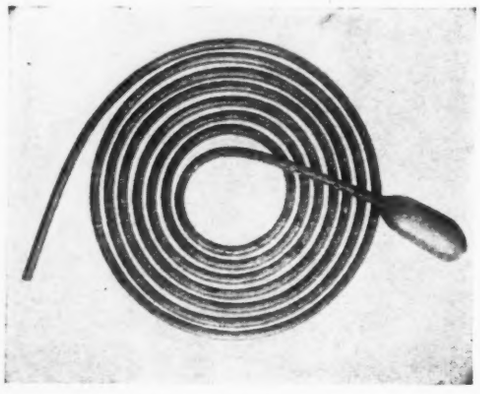
WASHINGTON, D. C.—Of the initial allocation of 410,625 grams of streptomycin for March, 247,700 grams went to civilian use, according to C.P.A. The initial overall March allocation was larger by 84,370 grams than that of the February initial allocation.

Other March allocations were apportioned as follows: armed services, 30,000 grams; chemical research, 18,935 grams; American Trudeau Society clinical program (tuberculosis studies), 9000 grams; export, 75,000 grams.

Allocations of streptomycin to the Veterans Administration have increased from 7500 grams in October of last year to 28,500 grams in March. More of the drug is being used in V.A. hospitals for the treatment of tuberculosis and requirements will probably rise sharply. The U. S. Public Health Service likewise has indicated that its requirements probably will increase substantially in 1947. The Office of International Trade has asked for more than three times the present export quota.

Increased production will be necessary, according to C.P.A., to meet these indicated increases in future requirements.

A *simplified* tube for
INTESTINAL INTUBATION



Described by Dr. Meyer O. Cantor, Detroit, American Journal of Surgery, July 1946; and in other articles soon to be published in the American Journal of Surgery.

The CANTOR TUBE

The CANTOR TUBE is a latex bag-tipped, mercury weighted, single lumen tube. It is 18 Fr. and 10 feet long. Its movement down the alimentary tract is actuated by a combination of free-flowing qualities of the mercury and the peristaltic action on the bolus formed by the mercury in the bag. Mercury is given the maximum motility by the loose latex bag attached distal to the tube. It is the only tube utilizing all the physical properties of mercury.

Tubes are marked as follows to indicate their position: "S" for stomach at the 17" mark, "P" for pylorus at the 24" mark, "D" for duodenum at the 30" mark, then in feet at the 4, 5, 6, 7, 8 and 9 feet marks.

Secondary dilatation of the stomach can be decompressed by withdrawing the tube a short distance, cutting holes into the tube, and allowing the tube to be pulled down by peristalsis at which point the holes will open to the stomach which, on applying suction, will be decompressed.

Replacement latex bags are easily cemented to the tube.

FEATURES . . .

1. ***Greater ease of intubation*—first, ease of passage through the nares and nasopharynx; and second, *ease of passage through the pylorus.* Of 100 cases 96% were *successfully intubated.***
2. ***More efficient decompression*—resulting from larger luminal diameter and *less possibility of plugging.***
3. **Complete absence of any metal parts which might injure the mucosa.**

D-110 CANTOR INTESTINAL DECOMPRESSION TUBE, 18 Fr., 10 feet long, with bag attached, with instructions for use. Each $7.50

D-110/B LATEX BAG for Cantor Intestinal Decompression Tube, with instructions for replacement of bag. (With each dozen bags one tube of D-110/C Cement is supplied without charge). Each $.60, Dozen $6.00

D-110/C RUBBER CEMENT for attaching replacement bags to the Cantor Tube. Each $.25, Dozen $2.50

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Danville Blue Cross Joins Chicago Plan

Jack Gage

Associated Hospitals of Danville, Ill., Inc., has been merged with the Blue Cross Plan for Hospital Care of Chicago, effective March 15, according to a recent announcement by Edson P. Lichty, executive director of the Chicago plan. Jack Gage of Danville, formerly director of the Danville association, will continue in charge of enrollment, public relations and hospital relations for the Danville area and adjacent territory recently taken over by Plan for Hospital Care, Mr. Lichty said.

The merger extends Blue Cross service to an area of approximately 300,000 population, bringing the total population served by the plan to 5,800,000. Total membership in the plan, including those added in the Danville and, earlier, Peoria mergers, is now 1,400,000, or nearly 25 per cent of the population.

Other Blue Cross plans operating in Illinois have headquarters at Alton, Decatur and Rockford.

Public Health Nurses Honored This Month

In recognition of their tireless efforts to help conquer disease and win better health for everyone, public health nurses are being honored throughout the nation during the week of April 20 to 26.

This year marks the 70th anniversary of public health nursing in the United States, Dr. E. A. Piszczek, health officer of Cook County, Illinois, said in a Public Health Nursing Week statement.

Today, 20,672 public health nurses in the United States serve 6,000,000 families a year. One out of every six families is visited by a public health nurse every year, he declared.

The work of the public health nurse has long been recognized as the backbone of the local health program, Dr. Piszczek said. As family health counselor, her advice on intimate health problems is continually sought.

Plan Changes Name

Effective April 1, Maryland's nonprofit hospital care organization changed its name to Maryland Hospital Service, Inc., a name, it was pointed out, that is more in keeping with the statewide nature of its operations inasmuch as there now are 450,000 Marylanders enrolled.

PENICILLIN BY MOUTH

Bottles of 12—
50,000 units each

The use of BRISTOL PENICILLIN TABLETS ORAL (buffered penicillin calcium) in the carry-over period following the remission of fever in acute infections is now established as sound practice in the avoidance of relapses. Such therapy, like these tablets, is now acceptable according to the high standards of the Council on Pharmacy and Chemistry of the American Medical Assn.

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1-2 oz. tubes. Content of calcium penicillin, 1000 units per gram.

BRISTOL PENICILLIN OINTMENT DERMATOLOGIC provides yet another means of applying this useful and versatile antibiotic. The Council on Pharmacy and Chemistry has also found that beneficial therapeutic results may be expected from the local application of this penicillin ointment in impetigo contagiosa, infectious eczematoid dermatitis, certain carbuncles and, in fact, all skin conditions in which the exciting organism is staphylococcus aureus and albus, streptococcus pyogenes and hemolytic and non-hemolytic streptococci.

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Immediately available through your usual source.

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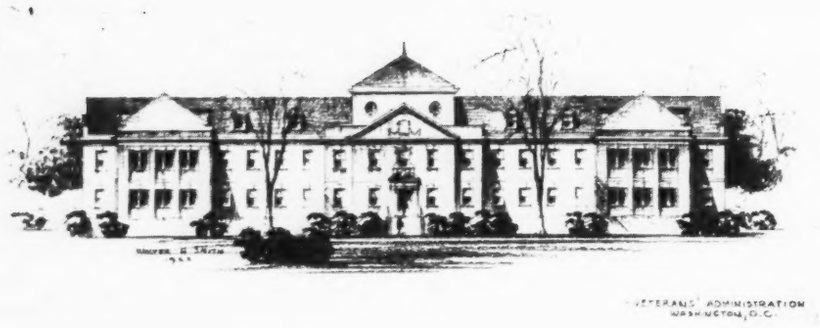


VETERANS' ADMINISTRATION
WASHINGTON, D.C.

Start Construction on Roosevelt Hospital

Construction is under way on the Franklin D. Roosevelt Hospital at Peekskill, N. Y., an $18,000,000 Veterans Administration project, the War Department reported last month.

A unique feature of the Roosevelt Hospital is its decentralization into 37 separate buildings, 13 of which will be used for hospital purposes with a total of approximately 2000 beds.

The hospital building includes units for tuberculosis, neuropsychiatry, chronic and convalescent patients, an acute general hospital, a women's hospital and the main clinical building which includes surgery, dental clinic, x-ray, laboratories, pharmacy and administrative offices. The separate buildings are to be connected by closed corridors.

Ohio Community to Have New Hospital

Their goal of $350,000 for a voluntary hospital has been substantially oversubscribed by the citizens of Cambridge, Ohio, who at last reports had contributed $392,000 for the project.

Incorporated as Guernsey Memorial Hospital, the proposed institution will provide for 102 beds and 30 bassinets. The hospital will apply for a minimum of $175,000 in federal funds under Public Law 725 to finance the building program thoroughly.

An unusual feature of the campaign, which was directed by Ketchum, Inc., of Pittsburgh, was the absence of relatively large gifts. The bulk of the money came from a great number of small contributors. The largest gift was $15,000 from the Continental Can Company.

The new hospital's affairs are being directed by an interim board of trustees which will be replaced by a permanent board of lay trustees to be elected by donors to the hospital fund. Every donor will have an equal voice in the election.

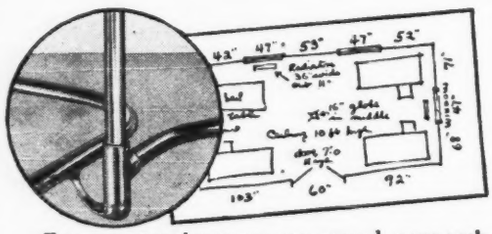
New Jersey Plan Reaches Million Mark

Hospital Service Plan of New Jersey reached an enrollment of 1,000,000 members April 1, J. Albert Durgom, executive director, announced. Since its organization in 1932 to the end of March this year, payments made and accrued by the plan for hospitalization totaled $23,801,191 for benefits covering 358,623 hospital cases served for 3,426,359 plan patient days.

H. Theodore Sorg, plan president, stated: "Enrollment of the first million persons under Hospital Service Plan of New Jersey is another milestone in the extended usefulness of the plan as a community service on a statewide basis. Successful performance of the plan is attributed to the cooperation of the hospitals, medical profession, employers, newspapers and all other sources of public relations in making available a nonprofit service at minimum cost for the benefit of the subscribing public among all walks of life."

ONE-BED PRIVACY

Crowded wards are usually a problem when attendants attempt to give patients the best of care. JUDD CUBICLE CURTAIN EQUIPMENT assures single-room privacy for examinations and night-care without embarrassment. And other patients sleep undisturbed when bed-lamps are shielded by cubicle curtains.



For a cost estimate on your ward, sunporch, corridor, or room installation, send us a simple sketch like the one above.

Heart of this modern equipment is the JUDD patented corner fixture. Curtains glide silently past it on fibre-encased wheels, completely enclosing the bed in a flash.

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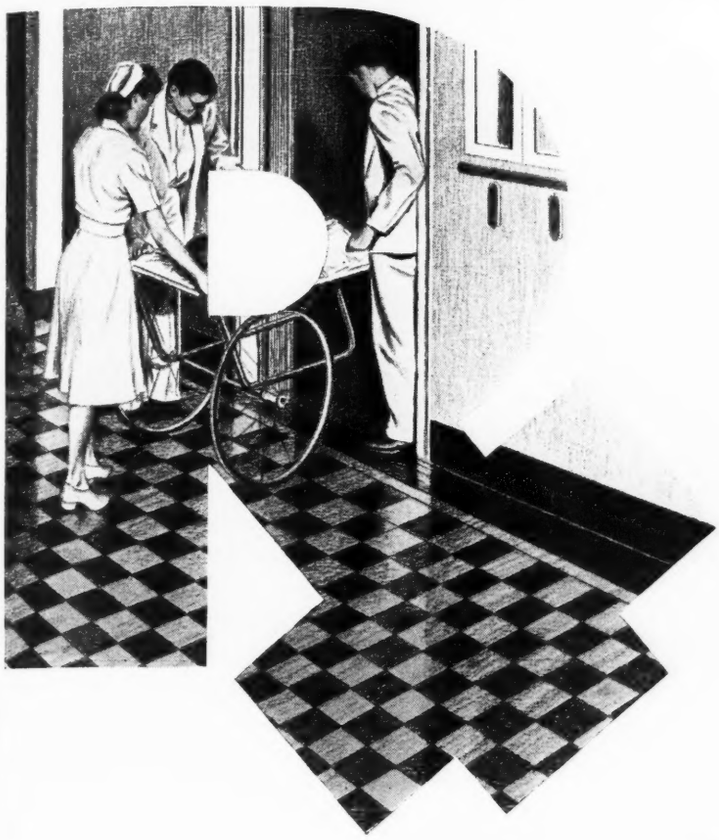

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Experienced hospital people who know the vital part that flooring plays in preparedness "prescribe" Hood Rubber or Asphalt Tile. They know it looks better, lasts longer and is easier to clean. They know it has quiet comfort, cheerful colors and attractive designs.

Hood mastery of manufacture, combined with B. F. Goodrich leadership in research, provides the *Super-Density* that eliminates dirt-catching pores and assures the permanence of resiliency and color.

Be sure *you* are prepared. Write at once for the new catalog showing Hood Resilient Flooring, Hood Rubber Cove Base and Hood Molded Stair Treads—choice of *experts* since 1925.

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CHICAGO 13

Refresher Course for Nurse Anesthetists in New Orleans

A refresher course in physiology of circulation and respiration will be offered at an Institute for Nurse Anesthetists in New Orleans, May 26 to 30. Other topics for discussion will include intocostrin, endotracheal anesthesia, analeptic drugs, fundamental principles of chemistry and gas therapy. Registrants at the institute will have an opportunity to observe and perform experimental intubation of dogs and to attend clinics in New Orleans hospitals.

Dr. Hugo V. Hullerman, assistant director of the American Hospital Association, and Ann Campbell of the American Association of Nurse Anesthetists are in charge of the institute. Sponsoring organizations include the Louisiana Hospital Association and Louisiana Association of Nurse Anesthetists.

Registration at the institute will be limited to 120 persons, who must be members of the American Hospital Association or the American Association of Nurse Anesthetists or represent an A.H.A. member institution.

Senate Holds Hearings on Proposed New Federal Department

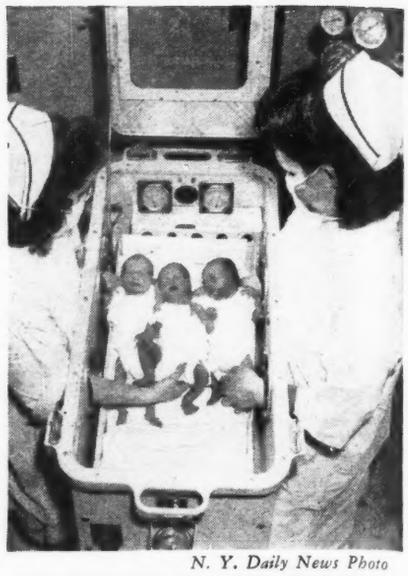
WASHINGTON, D. C.—Hearings were held March 17 to 25 before a Senate subcommittee on S. 140 and S. 712 to create a Department of Health, Education and Welfare.

Among those testifying were: Watson Miller, Federal Security Administrator; Elizabeth Wickenden, representing the American Public Welfare Association; Mrs. Mildred Netreber, League of Women Shoppers, Inc.; Mrs. Richard J. Bernhard, National Child Labor Committee; Dr. George F. Zook, American Council of Education; Dr. Ernest L. Stebbins, director of School of Hygiene and Public Health, Johns Hopkins University, and Dr. Joseph H. Louchheim, Committee for the Nation's Health, New York City.

Bills on Veterans and Hospitals Considered

WASHINGTON, D. C.—The subcommittee on hospitals of the House veterans' affairs committee had under consideration as of March 18 the following bills:

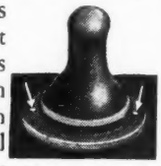
H.R. 784 providing compensation for attendants of mentally incompetent veterans in transit to veterans' hospitals or homes, and H.R. 321, H.R. 487 and H.R. 1456 all urging prohibition of pauper's oath requirement by certain veterans for hospital care.



N. Y. Daily News Photo

EVENFLO NURSER
Ideal for Tiny Babies

Getting tiny and premature babies to take enough food is often a problem. Because Evenflo has easy nursing action, this popular nursing unit in the 4-oz. size is ideal for their use in maternity wards. With Evenflo, both normal and subnormal babies finish their bottles better because their limited strength is not exhausted while nursing.



Valve action nipple nurses easier and does not collapse.

The wide mouth Evenflo bottles save valuable time for your milk lab technicians because they are easier to clean and to fill. Their plastic screw-on caps seal both nipples and formula against contamination. The nipple is easily placed upright for feeding. See your wholesaler for these modern hospital nursing units.

The Pyramid Rubber Co.
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4-Oz. Hospital Size

8-Oz. Size

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*in equivalent doses, no barbiturate for oral use combines more rapid, profound and shorter effect than...

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(PENTOBARBITAL SODIUM, ABBOTT)

FOR SEDATIVE EFFECT: Nembutal in ¼-gr. to 1-gr. doses

* Nembutal is a *powerful* barbiturate—so powerful that doses of less than 1½ gr. suffice for many patients and in many conditions in which brief sedative and only a mild hypnotic action is desired.
* In simple insomnia, for instance, a dose no larger than one ¾-gr. capsule usually obtunds emotional disturbances or reactions to outside stimuli sufficiently to induce sleep.
* Smaller dosage reduces the amount of the drug that must be eliminated, the duration of effect, and any slight possibility of "hang-over."
* Smaller dosage results in a monetary saving to the patient.

FOR TRUE HYPNOSIS: Nembutal 1½-gr. capsules

* Only one 1½-gr. capsule is needed, under most circumstances, to produce 6 to 8 hours of sleep under the influence of the drug.
* For preoperative sedation and as a basal anesthetic, prescribe one or two 1½-gr. capsules the evening before, and one or two capsules of the same size one or two hours before operation.
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A form to fit any short-acting sedative and hypnotic need

NEMBUTAL ¾-GR. CAPSULES—For the majority of cases in which sedative effect only is desired.
NEMBUTAL 1½-GR. CAPSULES—For surgical, obstetrical and all requirements for true hypnotic action.
NEMBUTAL ELIXIR—Contains 2 grs. per fluidounce; ¼ gr. per teaspoonful. Unusually palatable.
NEMBUTAL SUPPOSITORIES—In ½-gr., 1-gr., 2-gr. and 3-gr. sizes.
NEMBUTAL AND ASPIRIN—Nembutal, ½ gr., and aspirin, 5 gr. Sedative and analgesic.
EPHEDRINE AND NEMBUTAL—Ephedrine, ⅜ gr., and Nembutal, ⅜ gr.

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House Committee Boosts Grant to Cancer Institute

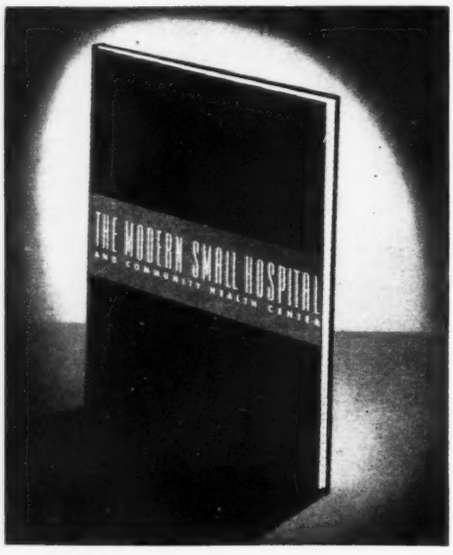
WASHINGTON, D. C.—The House appropriations committee approved March 21 a national grant of $17,328,200 for the National Cancer Institute. The grant more than doubled the sum recommended by the Budget Bureau. This appropriation for the National Cancer Institute, established in 1938, is greater than all its previous appropriations combined.

Some three fourths of the $17,000,000 appropriation will be expended for grants-in-aid and fellowships to institutions and individual researchers. In voting the grant, the appropriations committee said: "The committee hopes and believes that its recommendation to exceed the budget in order more adequately to provide for work on the cancer problem will be given full support by the Congress."

Approved also was a budget estimate of $2,650,000 for land acquisition and planning for a 600 bed hospital to be erected on the National Institute of Health grounds for clinical studies of cancer, heart disease, arthritis and degenerative diseases of middle and old age.

Book of Plans . . .

"The Modern Small Hospital and Community Health Center"



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42 Sets of Plans

Tells How to Organize, Finance, Design and Equip a Small Hospital and a Health Center.

The prize winning plans in The MODERN HOSPITAL competition for the best design of a small hospital and a community health center are in this big book.

Besides the twelve prize winning plans, there are thirty others that had features which attracted the attention of the judges.

In addition to complete plans, the book has articles by leading hospital and health authorities on setting up such an institution—the administration and professional organization—financing—construction material suggestions and check lists of supplies and equipment. The edition is limited.

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919 N. Michigan Avenue **Chicago 11, Illinois**

V.A. Conducts Advanced Courses for Nurses

WASHINGTON, D. C.—A total of 113 nurses has to date attended advanced courses which the Veterans Administration conducts for its nurses in neurologic, psychiatric and tuberculosis nursing and in the training of neuropsychiatric attendants, according to Dorothy Wheeler, director of V.A.'s nursing service. Courses, lasting from one week to three months, are under Miss Wheeler's supervision.

Classes in neurologic nursing, held at the V.A. hospital in Hines, Ill., place special emphasis on the care of paraplegic patients. The training carries credit points of 10 semester hours from DePaul University, Chicago. The course in advanced psychiatric nursing, conducted at the University of Minnesota, extends over a three month period and carries 15 college credit hours.

Instruction in the care of patients suffering from tuberculosis is being held at the V.A. hospital in Oteen, N. C. This hospital is being developed as a demonstration center for all phases of tuberculosis treatment.

Surplus Pharmaceuticals Offered by W.A.A.

WASHINGTON, D. C.—Three special offerings consisting of $300,000 worth of surplus chemicals and pharmaceuticals, $180,000 worth of parenteral solutions and $150,000 worth of sulfasuxidine tablets were announced March 8 by W.A.A.

The chemicals and pharmaceuticals include mercury bichloride tablets in bottles of 250 each; protein silver, mild and strong, 4.6 grain, in bottles of 100; iodine crystals in ¼ pound bottles; glyceryl trinitrate, 1/100 grain hypo, in tubes of 20 units. The sulfasuxidine tablets, 7.7 grain, are packaged 1000 to the bottle.

Approximately $1,750,000 worth of surplus unused hand tools and miscellaneous tools were offered at a sale which closed March 28.

Sugar Rationing May Continue

WASHINGTON, D. C.—On March 21 the House passed resolution 146, with amendments, to extend authority with respect to distribution and pricing of sugar. The resolution, in substance, provides for the continuance of sugar rationing and the pricing of sugar until the end of next October. A provision is included which would grant the Secretary of Agriculture the authority to continue inventory controls between Oct. 31, 1947, and March 31, 1948. According to the resolution all controls over the rationing of sugar would expire at the latter date.

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Anthony Van Leeuwenhoek, 1632-1723, maker of the first microscope, discoverer of the sub-visible world of germs and spores, was the first of the scientists known as microbe hunters.

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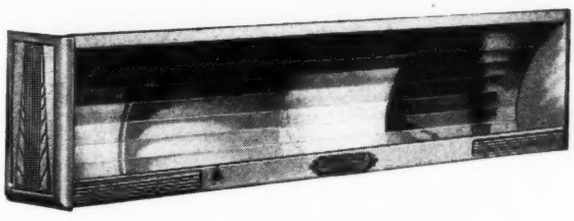

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Ultraviolet Germicidal Equipment

A.H.A. to Hold Purchasing Institute in Philadelphia

Efficient management of the hospital purchasing dollar will be the theme of the Institute on Purchasing which is to be conducted by the American Hospital Association April 14 to 18 in Philadelphia

Topics for discussion will include purchasing practices for large and small hospitals, centralization of purchasing, purchasing of specific items, such as textiles, foods and supplies, public relations aspects of purchasing, standardization and simplification and legal aspects of purchasing. In addition, there will be demonstrations.

Director of the institute will be Paul L. Burroughs, purchasing agent at Pennsylvania Hospital, Philadelphia, who is also chairman of the committee on purchasing, simplification and standardization of the American Hospital Association.

Persons eligible to attend include personal members of the American Hospital Association, administrators or persons charged with purchasing responsibility in association member hospitals or a member of the Hospital Association of Pennsylvania.

Write Regional Office for W.A.A. Surplus Items

WASHINGTON, D. C.—Some 34 additional long supply items and millions of dollars worth of surplus machine tools have been added to the list of surplus equipment now being offered at 5 per cent of fair value to public health and educational institutions, according to an announcement of W.A.A. March 19.

Hand fire extinguishers, fire hose nozzles, telescopes, magnifiers, combustion controls and measuring instruments are included in the revised order.

There will be no uniform distribution, according to a W.A.A. official, and there is no national inventory. Each regional office will have an inventory as the items are offered for disposal. Eligible hospitals are advised to write to the local public interest division of their regional offices and state their interest in specific items. When such items become available, the public interest division will notify the institutions that have made inquiries.

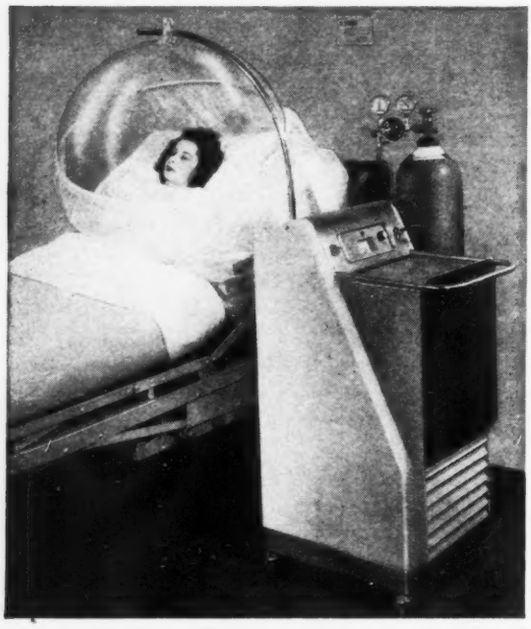
H.S.A. Is Financially Sound, Statement Says

WASHINGTON, D. C.—The Health Security Administration, belabored in the health and hospital survey here last year, stressed its sound financial condition in a statement released March 10. Twenty hospitals and health centers provided $537,410 in services to persons assisted by H.S.A. in 1946, according to Dr. Henry C. Macatee. Payments to the 20 institutions totaled $454,865, covering all but $82,544 of the amount due.

Dr. Macatee said that in present negotiations toward a new agreement among the Community Chest Federation, hospitals and H.S.A., every effort is being made to preserve those freedoms of action essential to the best public service. He deprecated efforts to weaken and in part destroy the function of H.S.A. to protect the medical profession against exploitation by the unworthy.

Bill Proposes U.S.P.H.S. Run Indian Hospitals

WASHINGTON, D. C.—Transferring the administration of Indian hospitals to the U. S. Public Health Service was asked by Senator Langer in a bill introduced March 5. All functions, responsibilities and duties of the Office of Indian Affairs relating to the maintenance and operation of hospitals on Indian reservations would be taken over by the U.S.P.H.S. Conservation of the health of the Indians would also be administered by the Public Health Service.



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Use our plastic Oxydome with it as shown, and you get high oxygen concentrations at lower than usual liter flows. Besides, the Oxydome affords window glass visibility. The two together represent oxygen tent therapy in its most modern and effective form.

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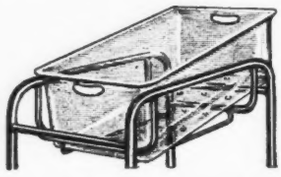
With plastic Oxydome instead of canopy, extra **$42.50**



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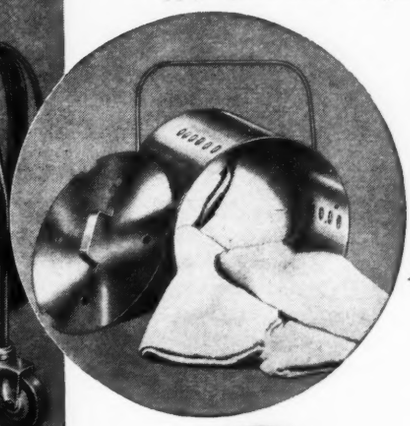
Any hospital staff acquainted with the Kenny Method of treating poliomyelitis can now be ready to administer hot packs efficiently, *anytime*—without tedious, time-consuming training, or heavy expense. This proven, labor-saving Vollrath Polio-Pak Heater fills the need of hospitals *everywhere* by preparing hot packs in quantity, quickly, with utmost convenience and safety.

The Vollrath Polio-Pak Heater is a complete, movable unit designed for use in a ward or at bedside, wherever there's an electrical outlet. So simply and efficiently does it operate—a nurse can be applying one set of hot packs while another set is steam-heating in the other handy Pak-Pail.



At all times, this unit stands ready to prepare a *continuous* supply of hot packs. While specially developed and tested to facilitate the Kenny Method of Treatment—The Vollrath Polio-Pak Heater is equally efficient in preparing packs for the treatment of infections, vascular and muscular congestions—in fact, for any physical therapy wherein either hot *moist* or hot *dry* packs are required.

Made of polished stainless steel, with no moving parts to wear out or need repair, the Vollrath Polio-Pak Heater is built for years of service. Available for immediate delivery, a demonstration will prove that, with it, you can accept the challenge of poliomyelitis, *anytime!*

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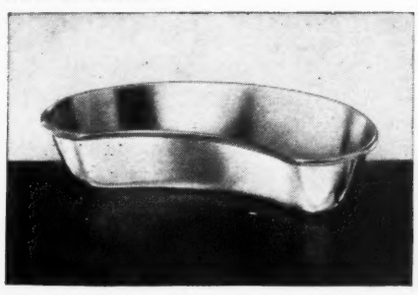

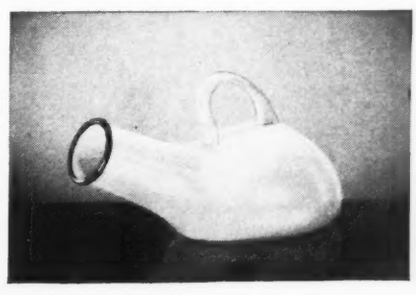

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Blood Transfusion Apparatus for Sale as Army Surplus

WASHINGTON, D. C.—About 140,000 sets of blood transfusion apparatus will be offered for sale on a competitive bid basis, W.A.A. announced March 11. The sets are unused army field models of the indirect recipient type designed to be used once and then destroyed.

Each set consists of a sealed-in metal tube with glass filter housing, metal filter, a 3½ foot length of rubber tubing, an 18 inch gauge, 1½ inch recipient needle and a 17 gauge, 1½ inch airway cannula needle. Use of this apparatus requires a donor set or a supply of blood, as in a blood bank, for complete transfusions.

Priority claimants may submit letters of intent to buy. All levels of trade, including hospital supply houses, manufacturers and exporters, are invited to submit bids for part or the entire lot in each region.

Bids will be accepted by the three W.A.A. regional offices holding inventories—New York, Chicago and San Francisco—from April 10 to April 30.

Open School to Train Hospital, Nursing Aides

A school for training hospital and nursing aides will open in St. Louis April 14 with an initial class of 30 students, according to a recent announcement by Samuel D. Conant, president of the St. Louis Council on Community Nursing. The training program is sponsored by the Missouri Pacific Hospital Association and the Deaconess Hospital School of Nursing. It is approved by the Community Nursing Council.

The curriculum recommended by the national association for practical nurse education will be followed to prepare students for the care of semiacute, convalescent and chronically ill patients in the hospital and at home.

The course will run for a year; it is open to women between 19 and 45 years old with an eighth grade education or its equivalent.

Physical Medicine Congress

The twenty-fifth annual scientific and clinical assembly of the American Congress of Physical Medicine will be held in Minneapolis during the week of September 2, Dr. Walter J. Zeiter of Cleveland, executive director of the congress, announced recently. In addition to scientific and clinical sessions to which all physicians are invited, the congress will also include courses of instruction for physicians and registered physical therapy technicians, the announcement said.

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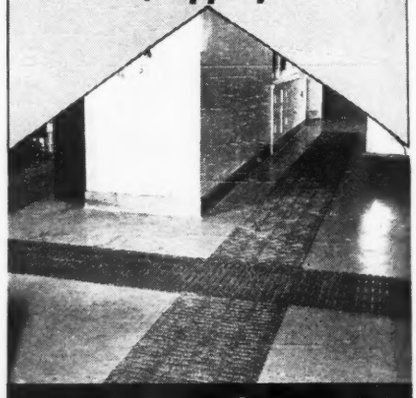

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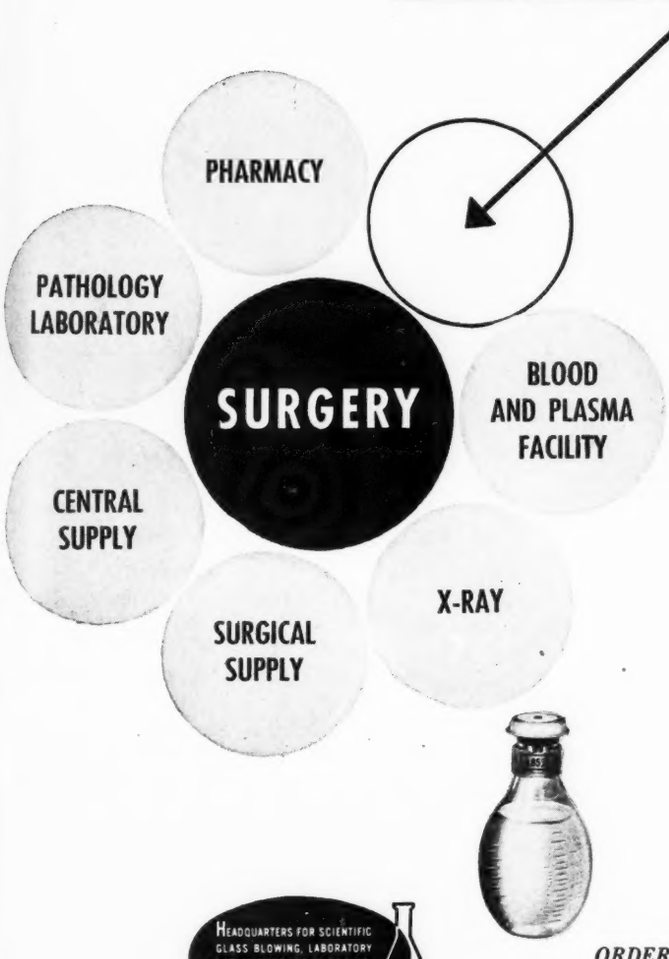

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is the installation of choice of many leading hospitals throughout the world, who enjoy the benefits of low-cost surgical solutions, as required. Of economic significance, a major proportion of Fenwal Parenteral Fluid equipment is essential to the blood bank facility as well.

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Physical Restoration Conference at Capital

WASHINGTON, D. C.—Nationally known authorities in the field of physical restoration conferred with representatives of 13 eastern states and the District of Columbia vocational rehabilitation agencies for disabled civilians during a three day clinic here March 24 to 26. The clinic, first of its kind ever held, will be the model for subsequent clinics which the Office of Vocational Rehabilitation will conduct in other regions of the United States. Dr. Thomas B. McKneely, chief medical officer of O.V.R., and Dr. Charles L. Newberry were in charge of the clinic.

Among those participating were: Dr. George A. Deaver, New York City; Dr. Frederic A. Gibbs, Chicago; Dr. Winfred Overholser, Washington, D. C.; Dr. Henry A. Kessler, Newark, N. J.; Dr. Carl Peterson, Chicago; Dr. R. E. Bruner, Baltimore; Dr. Jack Masur, New York City, and Clark D. Bridges, Chicago.

Organize Rural Council

The Southwest Missouri Hospital Council, representing hospitals in nine counties, was formed at a meeting held at Freeman Hospital, Joplin, in March. This is the first of several rural councils to be established throughout the state in accordance with recommendations adopted by the Missouri Hospital Association at its annual meeting in St. Louis last November. Officers of the new council include: president, Mrs. Josephine Y. Tisdell, superintendent of Freeman Hospital, Joplin; vice president, Dr. George Newman, medical director, Barry County Hospital, Cassville, and secretary-treasurer, Dr. Melvin C. Bowman, medical director, Sale Memorial Hospital, Neosho.

Ball Point Pens Prohibited

The New York City Health Department has prohibited the use of ball point pens for the preparation of vital statistics records, it is reported by the Hospital Bureau of Standards and Supplies. New York hospitals under this ruling may not use ball point pens for medical record purposes, it was explained. "This regulation was put into effect because of the impermanence of some ink in ball point pens and the fact that the ink had a tendency to strike through and make the information on the back of records illegible," the Hospital Bureau's bulletin states.

National Pharmacy Week

The American Pharmaceutical Association has completed plans for observance of National Pharmacy Week April 20 to 26, according to an announcement from the association's information bureau in Washington. Pharmacists all over the country have been supplied with leaflets, posters and stamps based on the 1947 theme of cancer control, the announcement said. The association has also furnished addresses, radio scripts and display material for use by pharmacists in stimulating public interest.

Maryland-D. C. Meeting

The annual spring conference of the Maryland-District of Columbia Hospital Association will be held at the Wicomico Hotel, Salisbury, Md., May 23 and 24. Tentative plans for May 23 include a general luncheon, general afternoon session, with possibly six speakers, a meeting for hospital trustees only and a dinner. The program the following day will include a general morning session and a luncheon for the board of trustees and the coordinating committee only.

Completes 30 Bed Addition

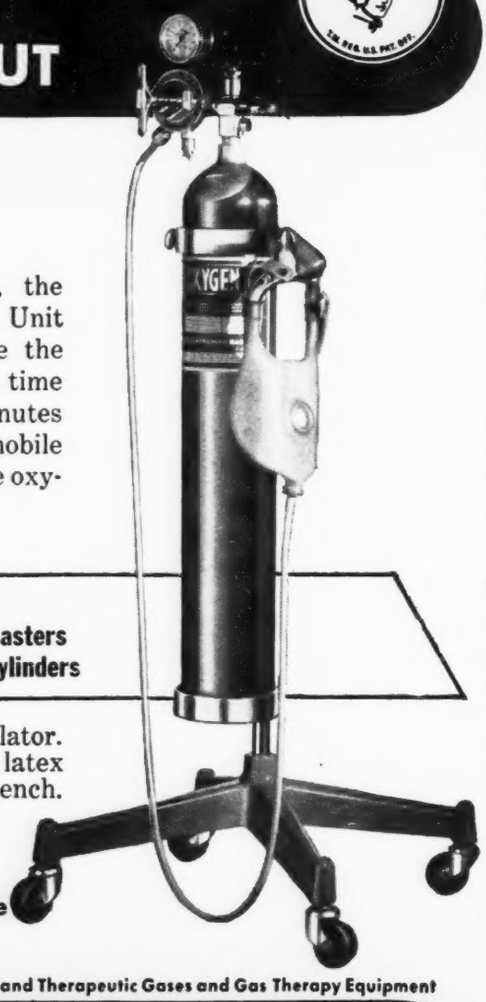
A 30 bed addition to St. Luke's Hospital, Milwaukee, has just been completed, according to an announcement by L. E. Zastrow, hospital president. The addition was built in four months at a cost of $40,000, the announcement said.

OXYGEN ON ITS TOES

FOR ANY EXIGENCY

PURITAN ROLL-A-BOUT OXYGEN UNIT

With quiet efficiency, the PURITAN Roll-A-Bout Unit glides into position beside the patient — saving precious time in emergencies when minutes are measured — offering mobile convenience during routine oxygen therapy.



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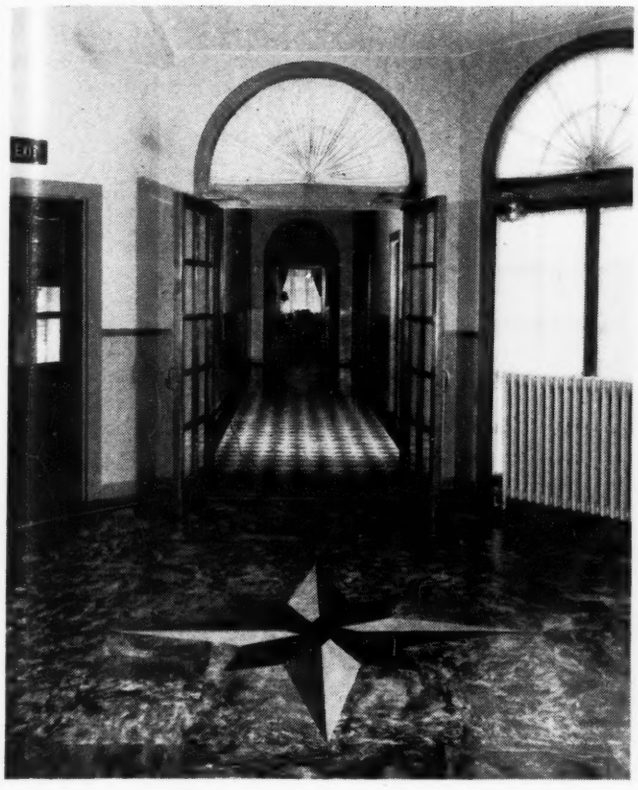


These photographs were taken 17 years apart

WHICH IS WHICH? Both photographs show the floor of Armstrong's Linotile in the lobby and one of the corridors in the Hospital for Crippled Children, Elizabethtown, Pa. The picture at left was taken when the Linotile was installed in 1930. The one at right was taken February 1947. From a comparison of these unretouched photographs it's easy to see there's little change in this floor—yet it has been subjected to the heavy traffic of a busy hospital for seventeen years.

Such unusual durability is typical of hundreds of installations of Armstrong's Linotile that have been made in hospitals since 1921. Many of them have been in service for fifteen, twenty, and twenty-five years. And Linotile offers other important advantages for hospitals.

The resilience of Armstrong's Linotile provides a floor that is both quiet and comfortable underfoot. Footsteps produce little sound on its surface. And it helps to lessen fatigue and strain on nurses and other staff members who are on their feet many hours of the day.

Linotile floors are easy to keep clean and sanitary, too. Dust can't cling to its mirror-like surface—the almost invisible joints between blocks can't harbor dirt. Unharmed by most spilled liquids, this floor is highly resistant to stains. Routine sweeping and occasional washing and waxing are all the care it needs.

What's more, the rich beauty of a Linotile floor helps to create a cheerful atmosphere for patients and staff. Linotile is available in a variety of colors. And because it's hand set, a block at a time, this floor can be designed to harmonize with any interior decoration. For free samples and literature, write to Armstrong Cork Company, 5704 Duke Street, Lancaster, Pennsylvania.

Resilient floors of

ARMSTRONG'S LINOTILE

"Standing Room Only" at New England Meeting

(*Continued From Page* 116.)

last year's contributions to 554 community funds. Mr. Cutler emphasized that he was speaking in terms of the immediate future. He is optimistic for the long term outlook in America.

Speaking on the same subject, Dr. Vane Hoge, medical director and chief, Division of Hospital Facilities, U. S. Public Health Service, stated that even now with hospital occupancy at an all time high, and with more money in circulation than ever before, many hospitals are finding it increasingly difficult to meet their pay rolls. He indicated that because of the inordinate rise in labor and material costs, this situation may get worse before it gets better. He said: "It is to be expected that the public's ability or willingness to pay the current high price of hospital care will decline more rapidly than will the cost of hospital operation. In view of these conditions, the fact must be faced squarely that the economic stability of the voluntary hospital is not only a problem for the future but an immediate and serious problem of today."

In answer to the question of "What Constitutes Good Trusteeship?" Dr. Frederick T. Hill, medical director, Thayer Hospital, Waterville, Me., replied: "Good trusteeship must endeavor to strike a balance between professional idealism and good business policies. Business acumen and sound financial policies are necessary but there must be a generous admixture of humanitarianism, of idealism and, many times, even of sentiment. A hospital bereft of these soon becomes ischemic and gradually atrophies." (A condensation of these and other papers and discussions presented before the Trustee Institute of the New England Hospital Assembly will appear in a special portfolio in the May issue of The Modern Hospital.)

Physical planning of the modern hospital, and particularly of the small hospital, was described by Lewis J. Sarvis, architect, Battle Creek, Mich. Mr. Sarvis believes that the U. S. Public Health Service space standards for small hospitals are extravagant. He referred to the fact that a 21 by 37 foot kitchen for a 50 bed hospital has proved successful whereas the U.S.P.H.S. requires approximately twice that amount.

James H. Hughes, chief engineer, Eastern Maine General Hospital, Bangor, Me., urged that in the construction of new buildings the maintenance engineer be given the opportunity to consult with the architect, permitting him to point out a number of small ideas that may eliminate unnecessary expense later.

Here are suggestions for a real program of executive housekeeper training as advanced by Dr. Mary DeGarmo Bryan, head of institution management, Teachers College, Columbia University:

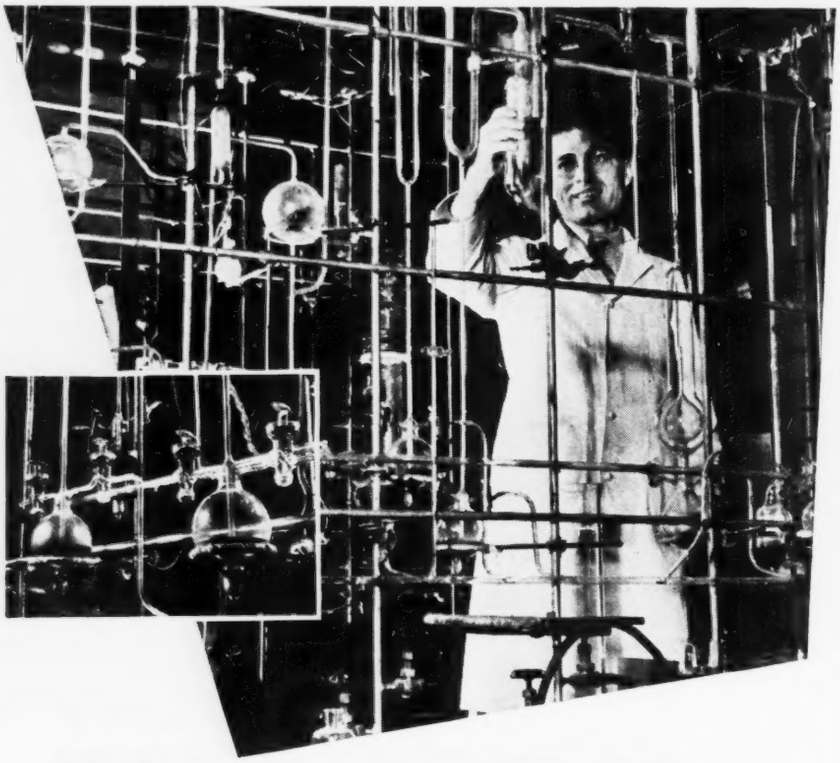
1. Recognition of the imminent need for an organization of courses within available college departments for the purpose of training executive housekeepers. It would seem advisable to organize this training on three levels because of the varied amounts and types of responsibility carried by housekeepers in different types of hospitals. These levels should certainly include graduate training for persons who are to handle large administrative positions, lecture in college courses for housekeepers and serve as supervisors of in-service training for executives.

2. Undergraduate training in the hundreds of colleges now offering courses in home economics and allied courses which will be needed by the housekeeper.

3. Courses at the two year institute levels.

4. Establishment of apprenticeship training in hospitals.

"It is evident," Dr. Bryan stated, "that much of the information needed for establishment of the training in the executive housekeeping field is already available but its selection and integration must be planned by persons experi-



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Because American's business life has been spent in planning for the hospital, you can *"Plan with American"* safely and advantageously. Any inquiry sent to our home office, Evanston, Illinois, will be referred to our branch nearest you.

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enced in the field and well aware of its present importance and future development. It would seem important, therefore, to appoint a planning board, representing outstanding members of the profession together with interested hospital administrators, representatives of nursing education and of the dietary, engineering and laundry services."

In the session on personnel, W. Neil Chapman, personnel director, H. P. Hood and Sons, Inc., Boston, listed some of the goals that the average human being keeps before him. The worker, according to Mr. Chapman, wants respect, some physical comforts, understanding, some control over his own affairs, a sense of capacity for his performance and a sense of integrity in the organization. Among ways to ensure better personnel relations he enumerated: having more departmental and group meetings, talking over problems with employes and putting them "in the know." He also urged against procrastination in handling matters of personnel relations. Employe magazines, Mr. Chapman stated, do much to develop economic relations giving the worker the recognition that is his due. Above all he placed emphasis on the need for having good top management, a good organization pattern with efficient coordination and control and also open channels of communication.

The following officers and trustees were elected at the New England Hospital Assembly: Rev. Donald A. McGowan, director of Catholic hospitals, Archdiocese of Boston, president, succeeding Donald S. Smith; Dr. Albert G. Engelbach, director, Cambridge Hospital, vice president; Lester E. Richwagen, superintendent, Mary Fletcher Hospital, Burlington, Vt., reelected treasurer, and Paul J. Spencer, director, Lowell General Hospital, Lowell, Mass., reelected secretary of the assembly. New trustees are: Frank C. Curran, administrator, Eastern Maine General Hospital, Bangor, Me., and Mrs. Delight S. Jones, superintendent, Truesdale Hospital, Fall River.

Need for Medical Social Service Outlined to Army Medical Officers

General fear of the hospital, the medical procedure, the illness itself, the end results or death is common among hospital patients and underlines the need for medical social service in connection with hospital care, Sally Perlman, Red Cross medical social worker at Letterman General Hospital, San Francisco, told a staff meeting of army medical officers there last month.

This fear may not be expressed, Miss Perlman said, but it is often projected onto other aspects of the patient's situation. He may ask questions about the illnesses of others and may gather information from different sources, often resulting in great misunderstandings and undue anxiety, she stated.

"Another problem, namely, misconception of diagnosis, is quite common," Miss Perlman continued. "The medical patient knows he has an illness and may know the name, but what does it mean to him? Most people have never heard of many specific illnesses, and the patient may certainly have no idea what he has, let alone understand the implications, the need for bed rest, prescribed medication and other routines.

"Frequently we find that patients have gained a completely different conception of their illnesses or have not fully comprehended the interpretation given. This may be the result of erroneous preconceived ideas of disease, superstitions, too brief medical interpretations, misunderstandings of technical words, or emotional blocking in mildly or severely disturbed personalities. Even when the patient does seemingly understand his condition, it is necessary to offer continued encouragement or understanding.

"Taking all factors into consideration, it readily follows that if the pa-

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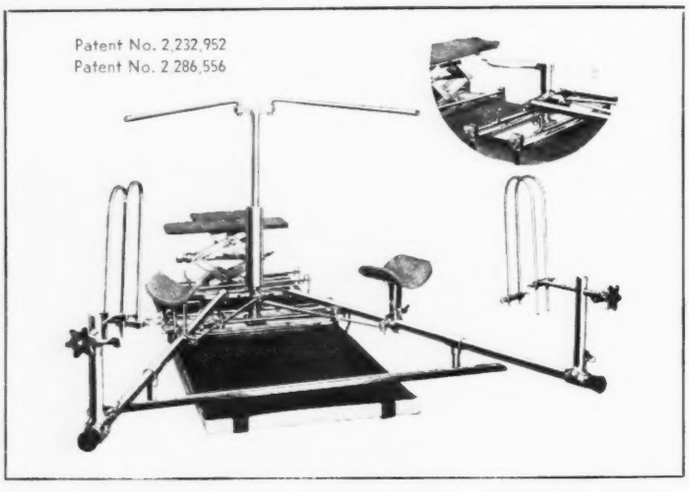

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tient understands the nature of the illness and the purpose behind the treatment, he can better be expected to cooperate.

"In this entire area the social worker can contribute to the patient's welfare and progress by bringing to the attention of the medical officer the patient's need for further explanation, by supplementing this explanation under the direction of the medical officer when he desires it, by recognizing other complicating factors arising from social or personality disturbances and by utilizing her casework skills to relieve tensions around illness and release energies in a more constructive direction."

ABOUT PEOPLE

(*Continued From Page* 84.)

of Duke University, Durham, N. C., Miss Rick served two years in the Pittsburgh office of the U. S. Civil Service Commission. In 1944 she became a member of an American Red Cross Clubmobile crew, serving in England and Germany.

Gloria C. Eppes is director of the newly organized personnel and public relations department at University Hospital, Augusta, Ga. Miss Eppes was graduated from the Henry W. Grady School of Journalism of the University of Georgia and has held positions on the *Banner Herald,* Athens, Ga., the *Daily News,* Miami, Fla., and the University of Georgia News Bureau.

Dr. Lloyd E. Hawes has been appointed chief of the department of radiology of Faulkner Hospital, Jamaica Plain, Mass. Dr. Hawes succeeds **Dr. Harvey R. Morrison.**

Mrs. Louise Sadler, R.N., has succeeded **Agnes Foelker, R.N.,** as superintendent of nurses at Western Clinic-Hospital, Midland, Tex. Before joining the staff of Western Clinic-Hospital, Mrs. Sadler was president of the Oklahoma State Nurses' Association and also president of the Oklahoma State Board of Nurse Examiners. She is director of the southern division of the American Nurses' Association.

Caroline Keller, director of nursing at Rochester General Hospital, Rochester, N. Y., since 1941, has resigned to accept a similar position at Memorial Hospital for the Treatment of Cancer, New York City.

Miscellaneous

Dr. Franklin M. Foote has been named to the post of executive director of the National Society for the Prevention of Blindness, New York City, succeeding **Mrs. Eleanor Brown Merrill,** who is retiring.

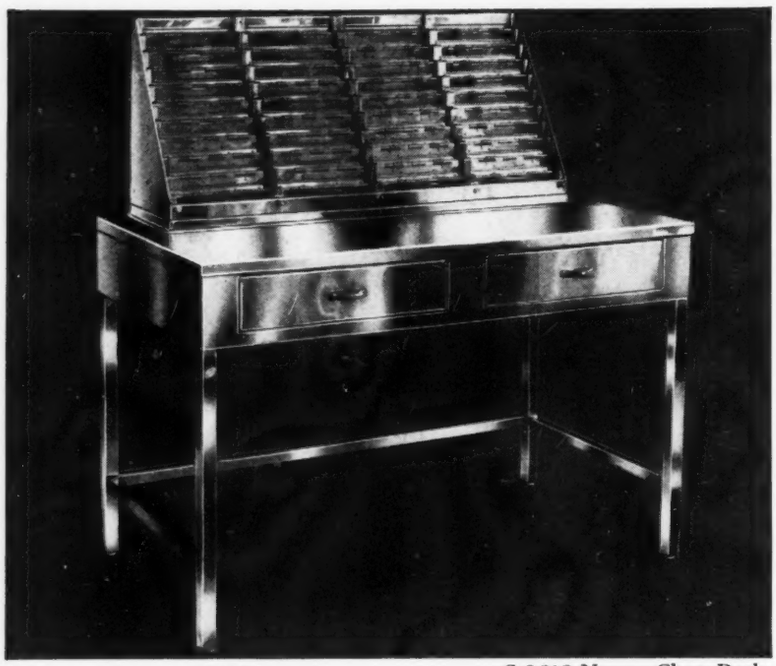
Dr. Donald G. Anderson, dean of Boston University School of Medicine, has been appointed secretary of the Council on Medical Education and Hospitals of the American Medical Association. Dr. Anderson, who succeeds **Dr. Victor Johnson,** will take up his new duties on July 1.

Thomas A. McCarthy has resigned as executive secretary of the Greater New York Hospital Association. Mr. McCarthy was forced into temporary retirement following severe injuries sustained in an accident. His resignation was accepted with regret by the executive committee of the association.

Dr. Alvin F. Coburn has been appointed head of Northwestern University Medical School's new Institute for the Study of Rheumatic Fever. The university was given $60,000 initial funds for the establishment of the institute. Included in this amount were $45,000 from the U. S. Public Health Service and $15,000 from the American Cyanamid Company, Lederle Laboratories division. Dr. Coburn was director of epidemic disease control for the navy during the war.

Deaths

Jarrett C. White, architect of Washington, D. C., who during the war was



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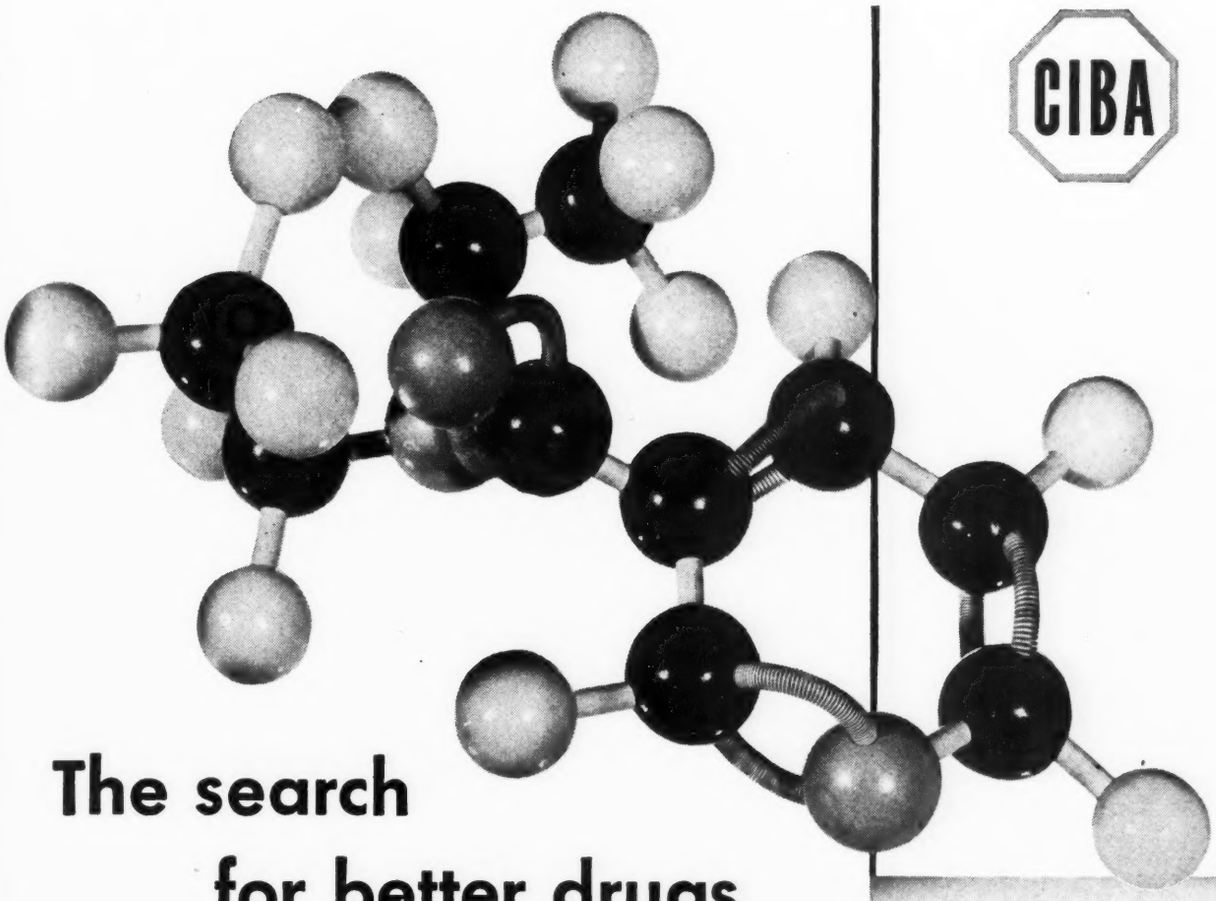

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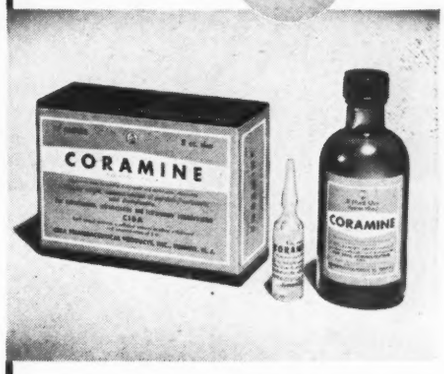

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from Today's Research

a consultant on hospitals to the Secretary of War, died March 16.

Gordon T. Broad, deputy commissioner of hospitals in New York City, died last month at his home in Brooklyn, N. Y. Mr. Broad served the city of New York for more than thirty years and had been for several years assistant to **Dr. Edward M. Bernecker,** New York City Commissioner of Hospitals.

Sister Anna Regina, superintendent of St. Joseph's Hospital, Pittsburgh, for almost fifteen years, died recently after a long illness. Sister Regina served as vice president of the Hospital Association of Pennsylvania.

THE BOOKSHELF

PRACTICAL NURSING: *An Analysis of the Practical Nurse Occupation, With Suggestions for the Organization of Training Programs. Washington, D. C.: Federal Security Agency and U. S. Office of Education. 1947.*

The sponsorship of this publication by the Federal Security Agency and the U. S. Office of Education and the caliber of the members of the committee responsible for its compilation, drawn as they are from the whole wide field of public welfare, bespeak in advance the importance of the subject under consideration.

A brief foreword by J. C. Wright, assistant commissioner for vocational education, explains the purpose and scope of the study and pays tribute to the many educators and organizations contributing either directly or indirectly to its production. The body of the book is divided into three parts, followed by an appendix (Summary Report of Conference on Practical Nurse Education, U. S. Office of Education, Washington, D. C.).

Part 1, the introduction, points out the significance of the present stage of development of the subject. The purpose of the bulletin is stated briefly under four headings:

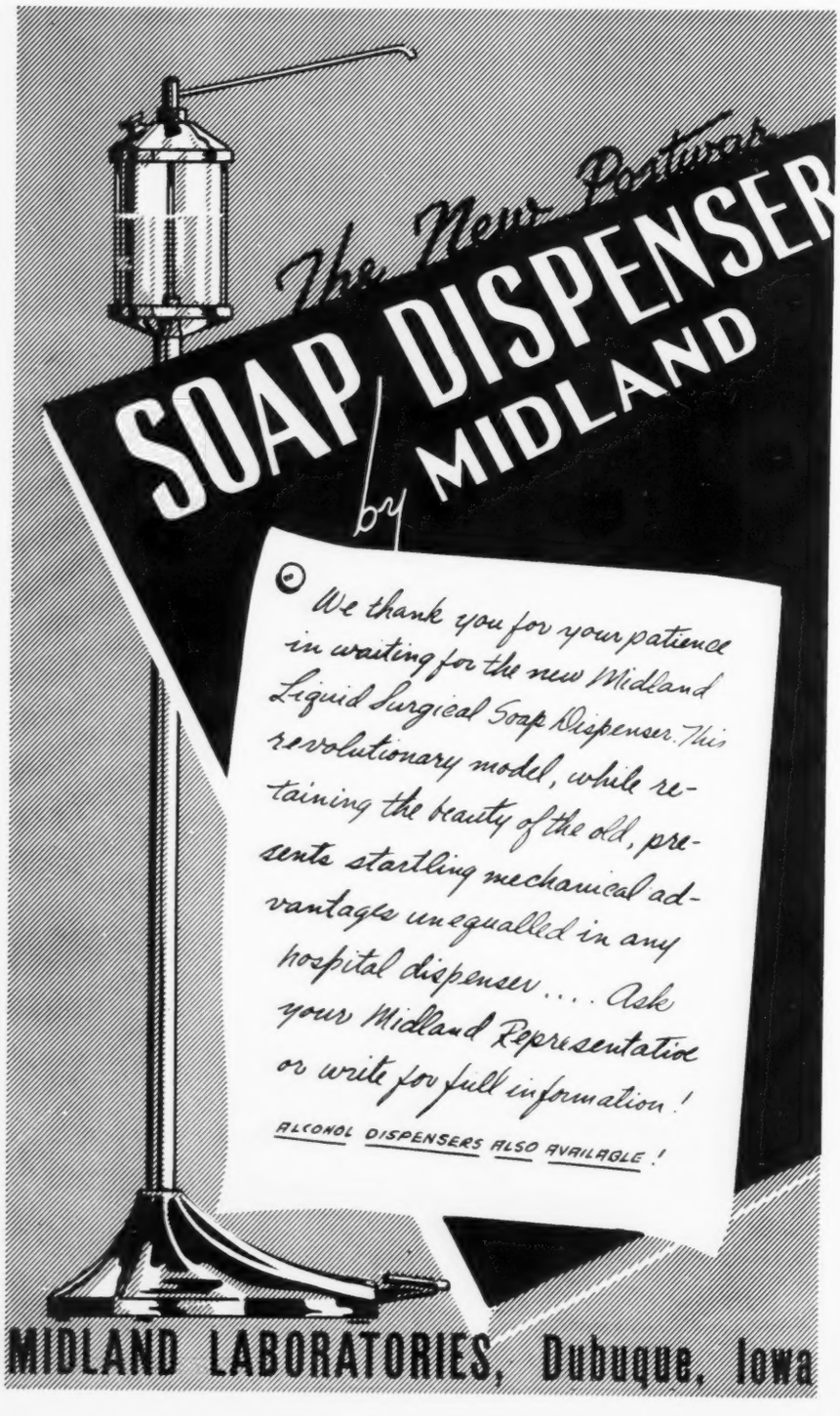
1. To provide a comprehensive analysis of the practical nurse occupation.
2. To identify the scope and limitations of each of the duties of the practical nurse.
3. To clarify the relationship of practical nursing to professional nursing.
4. To suggest general procedures for the organization of practical nurse training programs.

Then follows a description of the preparation of the analysis, with emphasis on the fact that it is suggestive only and that the final determination of the training content should be decided by representative advisory groups in the localities where training is to be offered.

The use of the controversial title "practical nurse" has been accepted for the following reasons:

1. There is great need that a title be used which requires a minimum of explanation to be understood.
2. The term "practical nurse" is more generally known, used and understood by the medical and nursing professions and by the lay public than is any other term suggested thus far.
3. The only national organization dealing exclusively with matters in this field is incorporated under the name "National Association for Practical Nurse Education."

A discussion of the present situation in practical nursing throughout the various states, 19 of which have some form of legislation regulating the practice of this group, leads up to a statement of the urgent need for increasing numbers of trained practical nurses in the care of a large percentage of subacute, chronic, convalescent and aged patients in institutions and homes.



New Names for

Iodine Tinctures

Effective April 1, 1947, the following names become official in United States Pharmacopoeia XIII and National Formulary VIII:

1. Iodine Tincture U.S.P. XIII

[Official in U.S.P. XII as Mild Tincture of Iodine]

Formula

Iodine	20 Gm.
Sodium Iodide	24 Gm.
Diluted Alcohol, a sufficient quantity, To make	1000 cc.

2. Strong Iodine Tincture N.F. VIII

[Official in U.S.P. XII as Tincture of Iodine]

Formula

Iodine	70 Gm.
Potassium Iodide	50 Gm.
Distilled Water	50 cc.
Alcohol, a sufficient quantity, To make	1000 cc.

It will be noted that there are no changes in either formula and, of course, no change in effectiveness. In addition to its value as an antiseptic and germicide, Iodine continues to serve the profession in many ways for the prevention, diagnosis, and treatment of disease.

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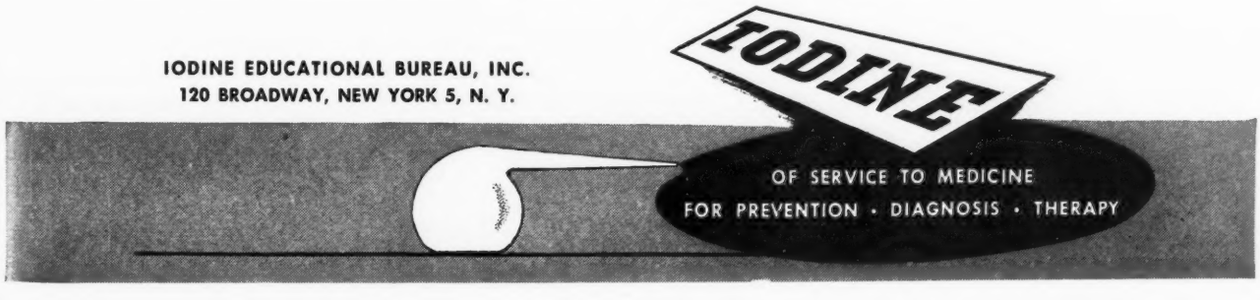

Part 2, "Analysis of the Practical Nurse Occupation," covers 130 pages and comprises the main body of the book. It contains a comprehensive and thorough analysis of the practical nurse occupation.

The range of duties of the practical nurse is covered in detail and classified under the following 10 headings:

1. Provide suitable environment for the patient.
2. Carry out personal hygiene procedures for the patient.
3. Provide for and maintain physical and mental well being for the patient.
4. Plan, prepare and serve foods.
5. Carry out and assist with diagnostic procedures.
6. Prepare supplies and surgical equipment.
7. Carry out therapeutic procedures.
8. Render special types of service.
9. Apply and remove bandages, binders and adhesive tape.
10. Care for the patient in emergencies.

The three major headings, with appropriate subheadings, used in the analysis are "What the Practical Nurse Must Be Able to Do," "What the Practical Nurse Must Use" and "What the Practical Nurse Must Know."

Certain nursing duties, concerning which there was not entire agreement of the committee, are omitted in this analysis. Several duties involving operation of types of equipment found only in institutions and other duties applying only to unusual situations in the home are also omitted. The committee acknowledges that insufficient emphasis has been given up to this time to the need for certain auxiliary units of instruction, such as personal hygiene, human relations and the characteristics and needs of various age groups. These areas of instruction are left to the discretion of the curriculum makers. The detailed lists of equipment for teaching purposes will be invaluable to instructors.

Part 3, "Suggestions for the Organization of Practical Nurse Training Programs," opens with a statement that federal money is available for the reimbursement of part of the cost of practical nurse training if it is under the supervision and control of public school authorities and approved by the state board of vocational training. Nine essential organization procedures are listed, such as the formation of an advisory committee, provision for qualified instructors, standards for selection of students and other procedures which do not differ materially from those used in any trade preparatory program.

As yet, no generally accepted curriculum guide for the field of practical nursing has been developed. However, certain factors are listed that will require careful consideration, including clear definition of work and functions, agreement as to fundamental objectives and development of a course of study.

Qualifications for teachers and trainees, physical facilities and teaching aids are described briefly. Mention is made of the groups from which trainees may be recruited, together with brief comment on such details as certificates and pins, uniforms for students and graduates, tuition and other charges, such as laundry, books and similar items. The matter of records, placement and follow-up programs completes the study.

Unlike so many studies on technical subjects, this material is eminently readable. The whole project has been carried out thoroughly and completely, but it is suggestive only—to be used as a guide rather than a bible.

While the advisability of including certain procedures within the limitations of the duties of a practical nurse might be questioned in some situations, the program is flexible enough to be varied according to the caliber of the practical nurse students and the supervision available. If I were called upon to develop a curriculum for the instruction of students of practical nursing, I should find this analysis of invaluable assistance.—Elizabeth W. Odell, R.N.

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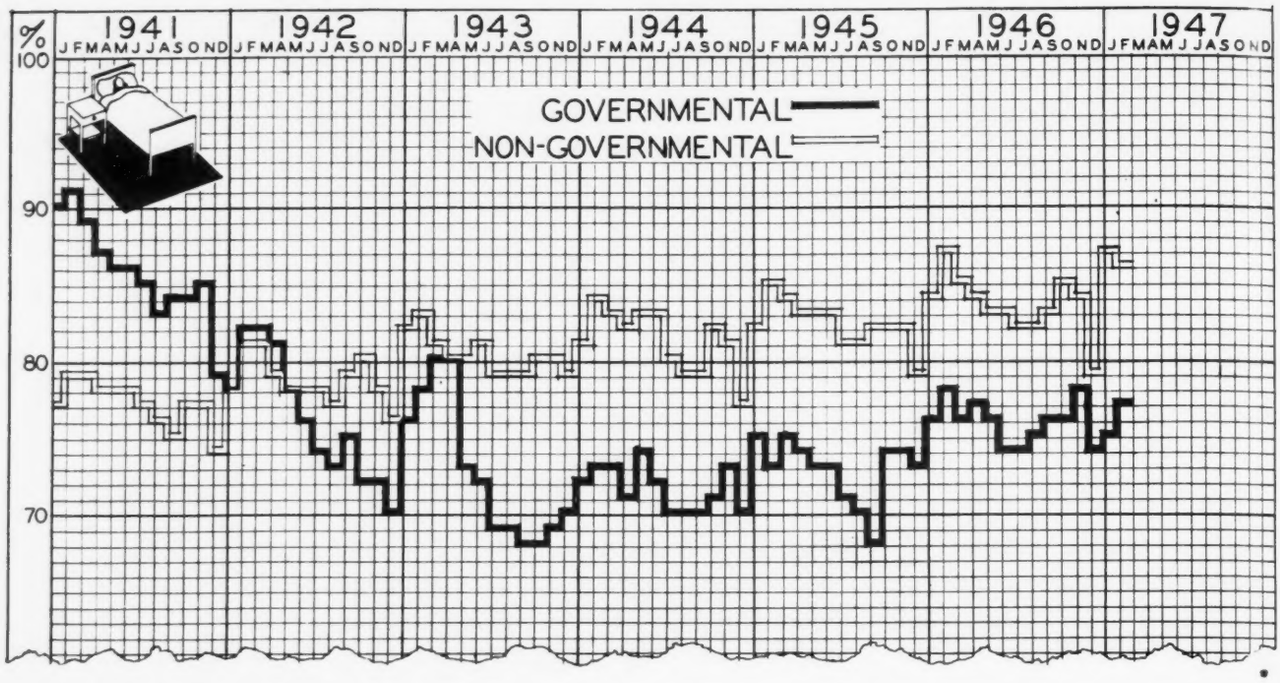
Voluntary Hospital Occupancy Drops Slightly



Many hospital administrators whose institutions are still bulging won't believe it, but the fact is that the occupancy of voluntary hospitals reporting to the Occupancy Chart was lower in February (86.0 per cent of capacity) than in the previous month (87.4 per cent). Governmental hospitals, on the other hand, were more nearly full in February—76.9 compared to 74.8 per cent.

Hospital construction projects reported for the third period of the year totaled $11,504,900, bringing the total reported for the year to date to $105,557,658. This is an increase of 77 per cent over the construction total reported for the same period a year ago. Of 20 projects reported for the current period, 11 were new hospitals and nine were additions. The new hospitals cost a total of $3,315,000 and the additions, $9,244,900.

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